IMPACTS OF BREASTFEEDING PEER SUPPORT PROGRAM ON WOMEN'S CAPACITY TO SUPPORT THEMSELVES AND OTHERS

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Abstract

This thesis draws on feminist theories of embodiment, empowerment, and intersectionality and their connections to women's experiences of breastfeeding. Through community engagement and co-operative inquiry, women's everyday experiences of embodied breastfeeding were explored for their insights into breastfeeding peer support at the Saskatoon Mothers' Centre. This research explores how interactions and conversations about breastfeeding knowledge and skills, based on differences in cultural perspectives, can lead to changes in subjective knowledge that underpins an expanded understanding of maternal capabilities, affiliation and collective agency. This exploration focused on understanding women's own perceptions of their breastfeeding experiences as an important source of maternal dyadic knowledge, as well as knowledge of the relationship between the body, self and others. The feminist literature on breastfeeding has tended to view breastfeeding as a slippery slope toward essentialism, a potential barrier to gender-neutral childrearing that is problematic for a feminist agenda for equality. This research addresses this imbalance and provides evidence to substantiate the claim that a non-essentialist feminist discourse of embodied breastfeeding–one that valorizes the breastfeeding body and its corporeal generosity and sociability–is a potential site of community resistance to medicalized birthing and breastfeeding initiation practices.

Key terms: breastfeeding, intersectionality, participatory action research, Saskatoon Mothers' Centre

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If you have come here to help me you are wasting your time, but if you have come because your liberation is bound up with mine, then let's work together.

Lilla Watson

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There were many conditions and supports in place that allowed for this research project to evolve. Peer relationship building at the Saskatoon Mothers' Centre (SMC) provided the space for neighbourhood women to engage in breastfeeding peer support work. From this safe space, six peer supporters were enabled to initiate and collaborate on this project. The Heath Promotion Department of Saskatoon Health Region allocated resources and assisted with the development of the SMC. In addition, the Saskatoon Community Foundation provided funding for the breastfeeding peer support program. Also, the SMC board supported the proposal, and individual board members and volunteers supported the ongoing research project. Saskatoon Breastfeeding Matters provided resources for breastfeeding training and supported various events.

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I am also indebted to my partner in life, Joe, and my family for their ongoing support and encouragement.

Dedication

I dedicate this work to the many women in my family's mother-line, to their courage and resiliency. It is through their stories of mothering that I came to know this caring work as an embodied resource for unconditional love and as a source of energy for gender justice. It includes my mother's stories of her experiences in her family and my first-hand experiences of the hardships she endured mothering as an immigrant woman in Canada. And it includes the many stories my aunts, my sisters, my cousins, my mother-in-law, my sisters-in-law and my daughter shared with me that opened me up to this life work.

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Introduction

Women's bodies are the means for childbearing while breastfeeding as an embodied maternal practice is promoted as a health and lifestyle choice. Breastfeeding, as part of human reproduction, is a biocultural and socially constructed practice embedded in women's specific social, economic, and cultural circumstances (Almeling, 2015; Head, 2017; MacLean, 1990; Schmied et al., 2012). Increasingly, more Canadian mothers are choosing to initiate breastfeeding after delivery (Gionet 2013). However, rates of continued breastfeeding drop within weeks after initiation, and this drop-off rate is increasing (MacKean and Spragins, 2012). Although there are a number of factors involved in the high rate of premature weaning (Gionet, 2013), the predominant struggle for breastfeeding women is to fit breastfeeding into their lives (MacKean and Spragins, 2012). Women are most challenged in their attempts to breastfeed when they are in public spaces (MacKean and Spragins, 2012) that are not breastfeeding "safe" (Boyer, 2012, p. 554). That is, women perceive that they have to negotiate their infants' needs to breastfeed along with potential negative attitudes towards breastfeeding in public spaces.

Women feel out of place when they breastfeed in public, where the cultural perception is that breastfeeding is a private act (Boyer, 2012) and a "solitary" one (Giles, 2018, p.189). Even in spaces where breastfeeding mothers are welcomed, there may be an unspoken expectation that mothers will cover up during the entire feed. This task can be impossible with babies who want to interact with their mothers as they nurse and resist being covered. Negotiating breastfeeding in spaces that are inhospitable can have negative effects on a woman's experience of breastfeeding, which, in turn, can lead to premature weaning (MacKean and Spragins, 2012). Public spaces, where mothers know that there is no risk of being criticized, are not readily available. The Saskatoon Mothers' Centre (SMC) is one of the exceptions. The SMC has intentionally been constructed to be a safe and supportive space for breastfeeding through the development of the Breastfeeding Peer Support Program.

Saskatoon Mothers' Centre

The Saskatoon Mothers' Centre is modeled on the concept of community-based mother centres which began in Salzgitter Bad Germany in the early 1990s. The concept grew out of a German Federal Government research project investigating the low uptake of parent education classes in the country. The first centre was designed as a democratic space run by its users, and it quickly

became a movement of 400 centres within the country, each addressing the German women's sense of social isolation associated with mothering. The centres were funded by federal and local governments with additional funding from the Save the Children Fund. The centres also provided services for immigrant women from East Germany and Turkey and helped them integrate into German society. The German Mothers' Center movement created public spaces for women from different walks of life to connect and develop a collective voice and influence public conversations about the needs of women and children. The Centre is recognized internationally as a model for community development. The movement, aided by the development of Mothers International Network for Empowerment (MINE) has spread from Germany to centres in 22 countries. In Canada, a centre in Vancouver began as an Aboriginal Mothers' Centre with federal funds and now operates with United Way funding.

Members of Saskatoon Breastfeeding Matters became aware of the Mothers' Center movement through a book borrowed from the local library entitled *A Tradition that has No Name* (Belenky et al., 1997). My visit to the centre in Salzgitter Bad in 1997, and my experiences there, led to community conversations with different groups in Saskatoon. Saskatoon Breastfeeding Matters hosted a series of demonstrations of a model Mothers' Centre at West Winds Primary Health Centre in 2008. An International Women's day event to discuss the potential of a Mother's Centre in Saskatoon led to the idea being incorporated into the architectural plan for a new community support centre, Station 20 West, that was built in the core neighbourhood. Saskatoon Population and Public Health Services (SPPH) approved the plan and provided funding for the space's rent for the first five years. During this time, SPPH Health Promotion Department provided staffing to help with organizing a board to run the centre and provided leadership development supports for host training. Saskatoon Mothers' Centre board obtained grants for programing such as sewing circles, cooking, communications, a book club and breastfeeding peer support training.

The SMC is a registered charitable organization that is structured as a public living room to support women living in poverty. The SMC was organized to follow the Mothers International Network of Empowerment (MINE) principles for mother-centered community building. The four basic principles are that the Centre is an intergenerational mother-child-friendly space, that the Centre provides women who work there with fair living wage pay for their work, that the Centre is organized to run from the bottom up in a non-hierarchal fashion through committees, and that the Centre is welcoming of all women and children who come to the Centre (Field Notes). In

addition, to these four principles, the SMC added non-violent communications as a core principle to deal with conflicts. In following these principles, **the** SMC remains open to all women of diverse cultures, races and classes. The Saskatoon Mothers' Centre (SMC) is located in a core neighborhood on the city's west side, that is characterized by a high proportion of low-income families (Neudorf et al., 2009) where unemployment rates are twice that of the rest of the city (Neudorf et al. 2009, p.86). Forty seven percent of the population live below Statistics Canada Low Income Cut-offs as compared to the 17.7 percent reported for the city of Saskatoon as a whole (Neudorf et al. 2009, p.81). The core neighborhood has higher rates of teenage pregnancy, low birth weight, and single parenthood. The upsurge in housing prices in 2007 and 2008 and the increase in rental costs along with low vacancy rates have pushed up to 6,000 individuals including women with children to "hidden homelessness" (Neudorf et al, 2009, p. 89). The core neighborhood has accepted an increasing number of immigrants and refugees, which tripled between 2006 and 2011 (Saskatoon Health Region, 2014). Twenty six percent of residents living in the six contingent core neighborhoods identify as having Registered Indian Status (Neudorf et al., 2009, p. 6).

The SMC has intentionally become a supportive space for women, who are doing mothering work. Six to ten community women, who are voted in by the membership at an annual general meeting, run the independent volunteer board. The hosts, who are representative of the population of that area of the city, are selected and trained to run the SMC drop-in programs for women and children. The hosts are neighbourhood women who have been trained to provide hosting functions for the drop-in programs. Training sessions offered to hosts include Food Safe, Mental Health First Aid, Nobody's Perfect Parenting, Traditional Tipi, moss bag teachings and breastfeeding peer support. The host coordinator chaired monthly team meetings to which all the hosts were invited. In these meetings, hosts were actively engaged in bringing up issues and concerns with hosting as well as making decisions about the way the Centre is run on a day-to-day basis. Hosts were paid an honorarium of $15 per hour for training sessions, hosting work, and attending meetings. Together, the board and the hosts work to ensure that the Centre is open to all women, is foremost culturally safe for First Nations and Métis, women who are doing mothering work. Through team meetings, they organize the SMC as a safe place for participants and their children. Women at the SMC have the opportunity for conversations with each other across

cultural, class, and age barriers about the experiences and issues in their day-to-day lives, including breastfeeding.

Breastfeeding rates are negatively impacted by social and economic disparities and are considerably lower for the Indigenous population than for other women (Eni and Phillips-Beck, 2013; Gionet, 2013). These lower rates are correlated with higher infant morbidity and mortality rates (McIsaac et al., 2015 Thus, it is critically important that First Nations, Métis, and Inuit women are able to find supportive places to breastfeed. Creating a breastfeeding safe space is a key goal of the SMC. This service is provided by hosts who have all completed a 20-hour breastfeeding peer support training module. In addition to one to one peer support, the SMC began providing bi-weekly drop-in sessions for breastfeeding women in October 2015. A First Nations woman trained as a birth doula, and one of other hosts, leads each session. Hospitality and nutritious food are a regular part of the sessions. A lactation consultant is on call if a mother needs more skilled care. This peer led program is attracting women from diverse cultural and class backgrounds in the neighbourhood, and it remains open to women from higher-income neighbourhoods.

This research project examined the effects of interactions and conversations that take place in a breastfeeding-safe space namely, the SMC. The research examined the effects of different cultures and values on the maternal practice of breastfeeding as an intentional woman-centered embodied practice. The main research questions in this project are what are the factors that constrain and support breastfeeding in women who have low incomes and what is the role of the SMC in supporting and empowering women who use the centre?

Chapter 1

Literature Review

Most women giving birth in Canada (89%) initiate breastfeeding in hospital, but only 26% are exclusively breastfeeding at six months (Gionet, 2013). In their critical review of 10 years of qualitative research, MacKean and Spragins (2012), found that for many women breastfeeding is a desired behavior but difficult to integrate into their lives. Their research findings suggest that the health care practitioner's view of breastfeeding as a health rather than a social issue, and breastmilk as a product rather than a relational activity, leaves women to work out the practical aspects of integrating their breastfeeding practices in a predominately bottle-feeding culture.

After giving birth, many women discover that breastfeeding can be a sensuously reciprocal experience that plays a pivotal role in maternal bonding and infant attachment. Sustaining breastfeeding is a biological relational activity that is both a physical and time-dependent practice that requires supports. Yet mothers face contradictory social and cultural values about breastfeeding in a society that values productive and sexual labour over maternal reproduction and childrearing. The decision to breastfeed as a "processual one," made and remade over time (Murphy et al., as cited in Head, 2017) has become for many women a decision-process fraught with tension and anxiety.

The reasons for early termination of breastfeeding are multifactorial. The social and economic disparities in women's lives affect how they negotiate infant-feeding in their particular situations. Representations of the breast as sexualized objects by western media have negatively affected women's experiences of breastfeeding in public spaces (Hausman, 2007; MacKean and Spragins, 2012). These representations create pressures on women to abandon maternal breastfeeding as they negotiate public and work spaces.

Since the 1980s, the global medical establishment led by WHO and UNICEF has promoted breastfeeding as an "evidenced-based" practice (Nathoo and Ostry 2009, pp.126-7). This approach has been presented as a lifesaving practice for infants and mothers in the two-thirds world, but was deemed unnecessary in the one-third world, which had adequate access to public sanitation. However, exclusive breastfeeding from birth has recently been elevated in the one-third world to a unique form of "personalized medicine" (Victoria et al., 2016, p. 486). Evidence of the microbial connection between mother and child immediately after birth, as a sensitive period for gene expression and health imprinting, has led to a revision of thinking among international health

professionals (Victoria et al., 2016). Breastfeeding from birth has been linked to protection against chronic diseases such as obesity and diabetes in the infant, and protection against diabetes, breast and ovarian cancers in the mother (Victoria et al., 2016).

The World Health Organization (WHO) has been influential in providing research on breastfeeding at the population level. A groundbreaking study on the growth of exclusively breastfed babies under optimally supported conditions (WHO Multicentre Growth Reference Study Group) was carried out in six different countries, including the USA. This research showed consistency in growth in breastfed babies across all these sites. The findings also showed the initial growth in breastfed babies was different than previously documented. Growth was higher for the first six months, and then lower so that babies breastfed to one year tend to be leaner (WHO Child Growth Standards, 2006). In 2006, the WHO released these new international growth charts as the new international standard for assessing healthy growth and development in the first two years of life. The Public Health Agency of Canada and Provincial Health Departments followed WHO recommendations promoting the use of WHO growth charts in Public Health offices, doctors' offices and pediatric wards. These standards replaced the original growth charts, based on growth of white babies in the USA that were mainly formula fed (CDC, 2015). These charts were promoted by US-based infant formula companies that published and distributed these growth charts free of charge for decades across North America. The growth charts often influence doctors to promote the introduction of infant formula or the early introduction of solids for exclusively breastfeeding babies when infant growth appeared to falter. This change in standards from mixed feeding to exclusive breastfeeding reinforces the medical rhetoric of 'breast is best,' a slogan initiated by Truby King in the earlier part of the last century (Wickes, 195, p. 500). However, as this policy effectively establishes breastfeeding as a biological norm and supports women who are successfully breastfeeding, it intensifies the pressure on those mothers who are struggling to establish or maintain breastfeeding in their everyday lives.

Within pronatalist societies such as Canada, which promote children as a norm of adult married life, women continue to be held fully responsible for the growth and development of their children. Breastfeeding in this context has been set as the gold standard for mothering an infant. This scientific validation of lactation as personalized medicine and breastfeeding as the standard for maternal bonding exert more pressure on women in their roles as mothers. Women faced with pressures to breastfeed can experience breastfeeding labour as a third workload, a responsibility

and burden of care, rather than a source of embodied pleasure and empowerment (Rosin, 2009). Most women are caught in a quandary (Flacking, 2006; Thomson et al., 2015) they are shamed if they breastfeed in public, or if they breastfeed for too long, or they are derided as inadequate mothers if they bottle-feed.

The response to this pressure among feminists has been mixed. Some valorize breastfeeding as a unique aspect of womanhood that empowers women to change the world (Bartlett, 2002; Hird, 2007; Shaw, 2004) while others criticize these pressures to breastfeed as based on inconclusive scientific evidence (Jung, 2015; Rosin, 2009; Wolf, 2011;), unrealistic for most mothers who are not white, middle-class, and married (Law, 2000). These standards are seen as additional burdens on women to be "good mothers" (Avishai, 2011; Wolf, 2011) and further exacerbate gender inequity (Bobel, 12001; Jung, 2015; Rosin, 2009). Some feminists argue that most women and their families do not have the resources to fully support their decision to breastfeed (Hausman, 2003; McCaughey, 2010). In contrast, some feminists suggest that white, middle-class women who breastfeed may have an important collective role to play by publicly contesting the negative social values associated with breastfeeding in public spaces (Bartlett, 2002; Boyer, 2011; Hausman, 2003). These privileged women may be able to exercise their power to demand every woman's right to breastfeed as an "ordinary aspect of embodied breastfeeding" (Hausman, 2003).

1.1. Feminist Theories On Breastfeeding and Embodiment

Feminists have recognized that, for women, the body is both a source of joy and of suffering, leaving feminists with an ambivalent understanding of the female body (Lennon, 2014; Davis, 2007). Since women bear children and lactate, they are deemed responsible for childrearing. Early feminist writers such as Simone de Beauvoir argued in 1953 that biology was responsible for women's subordinate position in modern society. In order to move beyond biological determinist arguments, Adrienne Rich (2002) distinguished between the experience of motherhood--the day-to-day practices and interaction between mother and child—and the institution of motherhood--the ideological practices and structures through which patriarchal constructions are inscribed on the mother-child relationship. Rich's distinction provided some understanding of the tensions that many women experience between the social and psychological experiences of mothering and the

public pressures to comply with conflicting norms, such as medical directives to breastfeed in order to promote optimal child development and social norms not to breastfeed in public.

Breastfeeding has not been one of the central dilemmas of feminism, which struggles with either minimizing gender differences or enhancing them, as the way to gender equity (Carter, 1995). Van Esterik (1989) contends that feminists have avoided taking on breastfeeding as this would privilege mothers over women–a contradiction for liberal feminists. From an ontological perspective, these dilemmas come from differences in understanding the body either as a biological organism where the body and mind are independent of each other, or where the body and mind are fully integrated (Spencer, 2007).

As a biological process, breastfeeding can mark women as encumbered (Hausman, 2007) and breastfeeding as a "time consuming task" (Stearns, 2013, p. 361). Framing breastfeeding as "biological" has reduced it to an instinctive and passive act (Shaw, 2004, p. 113). Relegated to the domestic sphere, breastfeeding mothers are unable to participate fully in the public sphere, the world of men (Hausman, 2003; Rosin, 2009). Caring for an infant in a maternal exclusive way can become a compulsory burden of care affecting women's autonomy. Knaak, (2006) Law (,2000) and Wolf (2011), argue that the medical rhetoric of breastfeeding continues to provide a biased view of the scientific literature that tends to persuade rather than educate, and in doing so, it undermines autonomy and trust. Furthermore, the medical rhetoric maintains patriarchal views of breastfeeding as "natural," and "passive" reaffirming biological essentialist understandings of women's bodies—to which feminists such as Jung (2015), Rosin (2009) and Wolf (2011) object. At the same time, the focus of feminist theories on women's equality leaves the experiences of women's maternal bodies under explored.

Although many feminists have focused on the social construction of biological differences, more recently some feminists have highlighted the interaction of the biological and social experiences aspects of breastfeeding (Blum, 1993; Hausman, 2003; Hird, 2007; Wolf, 2006). These feminists are calling for new ways of theorizing the material aspects of female embodiment and breastfeeding, while not falling into biological determinism or essentialism (Bartlett, 2002; Hausman, 2003; McCaughey, 2010). Some feminists argue that breastfeeding needs to be reframed as "sensuous, non-commodified experiences of our bodies" (Blum,1993).

Breastfeeding is an active process of an infant and mother working together (Stearns, 2013), an embodied experience that involves an interactive co-regulating social experience for

both mother and child. Embodiment can be directly experienced by the senses, impacting one's identity and one's comportment (Young, 2005). Embodiment is often perceived as a positive quality associated with bodily power, agency, and sovereignty, but as Kreger (2005, p.350) observes, it is a process of bodily transformation that "cannot be studied divorced from the conditions of our existence". Experiences of social inequalities become embodied, which in turn, affect chronic disease rates and ultimately mortality patterns. As Adelson (2005), Eni, Beck-Phillips-Beck and Mehta (2014) McGibbon (2018) point out, the poorer health of Indigenous peoples–compared to the rest of the Canadian population–is the embodiment of an unjust social, political and economic world. Gestational diabetes, for example, can be seen as an embodiment of inequity within First Nations maternal health (Adelson, 2005).

As an embodied practice, breastfeeding requires that the mother be in a calm and protected environment in order to engage in these bodily processes mediated by the body's response to skin-to-skin connections. Sellen has conceptualized this understanding of breastfeeding as the "corporeal generosity" of the maternal body to actively provide nutrition, protection, bonding, and attachment that ensure that the child thrives. "Breastsleeping" can also be an act of mutual care, where the mother synchronizes her sleep with her infant's sleep and feeding times (McKenna and Gettler 21), facilitating maternal recovery from pregnancy and birthing.

1.2. Breastfeeding as an Empowering Process

Some women, according to Meedya et al., (2015, p, 267) develop an "intrinsic" sense of their bodies' power through their ability to meet the needs of their child. Meedya et al., (2015, p.266) point to self-efficacy, "a belief in capability to organize and execute the course of actions required to produce given attainments"), as a key to the intrinsic power that strengthens a woman's confidence and success. Empowerment through self-efficacy as maternal agency can be transformative, one that highlights the functionality of women's bodies and fosters maternal identities (Fox and Neiterman, 2015; Meedya et al., 2015). This agency has the potential to influence power relations within families and the way partners work together to parent (Stearns, 2009).

In her 1989 study of 122 Canadian women, Maclean described women's experiences as "an overlooked source of wisdom about the nature of our lives (p.4). Empowerment through breastfeeding can be as developed as a strategy to challenge the medical models of infant feeding

and other medical interventions (Carter, 1995; Thulier, 2009). There are breastfeeding mothers who are aware of the constraining aspects of breastfeeding and are motivated through their actions to become activists. For some, breastfeeding extends to the community; they confront gender constraints and breastfeeding taboos (Boyer, 20).

1.2.1. Maternal Capability. Maternal capability requires supports as it relates to childbearing and breastfeeding through the provision of material and non-material conditions that enable women to have the freedom to choose childbearing on their own terms, in "their own surroundings and in the context of their lives" (Nussbaum, 1995, p.18; Smyth, 2018, p. 2). The capability approach is based on two normative claims: "The freedom to achieve well-being is of primary moral importance and the freedom to achieve well-being is to be understood in terms of people's capabilities; that is, there is "effective opportunity" to do and be what they have "reason to value" (Robeyns, 2007 p.7). However, according to Smyth (2018), the opportunities to fully develop maternal capability that includes breastfeeding is dependent on the creation of space and time that allow for the capability to be fully developed within the complexity of people's lives. Women must have the autonomy to "take and make" the role of mothering and breastfeeding as their own (Smyth, 2018, p.13), and they need maternal autonomy to experiment with their role through "interpretation and improvisation" (Smyth, 2018, p.13). Support for maternal autonomy, Smyth (2018, p.13) argues, frees women from the society's moral code for good mothering, which in her view, is problematic because it is "closed to interpretation." Women are expected to follow an imposed moral code rather than exercising their moral judgment. The "good mother" role becomes onerous as the mother assumes full responsibility of meeting all of her child's needs ahead of her own. Following "the good mother" code effectively strips the maternal role of its power and agency (Rich, 2002, p. 111). Autonomy, on the other hand, is the "freedom to develop intentions" as an aspect of a self-directed life and to exercise self-control in seeking to realize those intentions" (Smyth, 2018, p. 4).

By exercising choices to develop the capability to breastfeed, as a valued way "to do and be," women gain self-efficacy and a greater capacity for autonomy and self-determination (Robeyns, 2016; Smyth, 2018). The capability approach is also consistent with what O'Reilly defines as "empowered mothering" (2007, p.794), a counter-narrative to the stereotype of "patriarchal motherhood," which is reliant on experts. Empowered mothers utilize agency to make their own choices and take responsibility to ensure safe and healthy environments for themselves

and their children. Having realized that they have a capacity to breastfeed, mothers then have the "effective opportunity" (Robeyns, 2007) to do and be what they want as mothers. Mothers have the confidence and ability to speak with authority about their experiences, knowing that their voices will be heard. It is difficult for women who are mothering under duress to achieve agency consistent with empowered mothering (Middleton, 2006). Nonetheless, experiences under duress can lead to critical insights about how patriarchal culture can limit women's choices in establishing authority over their own bodies and their children. As a result, these women develop alternative ways of mothering. At the same time, women who choose to breastfeed but are unsuccessful may end up dealing with feelings of alienation, disempowerment and dependency (Dykes, 2006, p. 177), and they may also experience distress and role alienation (Smyth, 2018, p.2-3).

1.2.2. Resistance to Medical Models. Experiences of birthing and breastfeeding can be a site for the development of maternal thinking (Ruddick, 1989) and the acquisition of maternal authenticity and agency that resist medical/patriarchal constructions of maternity and motherhood (O'Reilly, 2013). For most women in Canada, breastfeeding is a form of maternal practice and care that has been medicalized and constrained to a feeding choice for their neonatal babies. Many women wean within weeks or months as they resume their work lives. Women who successfully integrate breastfeeding in their lives, focus instead, on the ways that breastfeeding can support their approach to mothering within the context of their lives. They overcome the private and public divide that constrains breastfeeding, as well as the maternal and sexual divide in their physical relationships. Continued breastfeeding can become an opportunity to be in community with other breastfeeding women and a source of self-care and healing, growth and development. In providing care in their own way, they are exerting what Smyth, (2018) identifies as "a reproductive right to care."

1.3. Factors That Impact Breastfeeding Practices

Women's maternal experiences are highly dependent on their material conditions, and for many, breastfeeding is a luxury rather than an option (Blum, 1993). In fact, the initiation of breastfeeding and the maternal practices to sustain breastfeeding is linked with one's positioning in terms of social class, age, race, marital status and ethnicity. Social positioning is linked to access to support

from caregivers and the health care system, and to the cultural impact of the established ideology of "good mothering."

1.3.1. Class, Age, Race, and Ethnicity. Breastfeeding practices can be significantly impacted by the intersections of race, ethnicity, age and class. The research on breastfeeding demonstrates that the more resources available, the more likely women are to breastfeed and for longer periods of time. The evidence shows that older, married, educated women in Canada are more likely to breastfeed than younger, single women (Gionet, 2013). Maintaining breastfeeding over a longer period of time can be sustained by paid maternity-leave options, financial top-ups, and workplace accommodations, including assistance from unions for human rights equity for breastfeeding[1]. In Canada, women who have lower incomes, work part-time, or do not meet EI requirements may be coerced to go back to work earlier than they may want.

Less-educated women, who are younger and single, are less likely to initiate or sustain breastfeeding (Gionet, 2013). First Nations women in Canada (Reading) and African-American women in the USA (Armstrong, qtd. in Blum, 1999, p.160) are less likely to breastfeed than white middle-class women. French-Canadian women living in poverty also are less likely to breastfeed (Groleau et al., 2013), as are women who live in Saskatoon in the core neighborhood (Partyka et al., 2010). Income is a major factor that shapes women's ability to sustain breastfeeding, and maternity protection, as mandated by the International Labour Organization, is limited in Canada. Women who have worked a minimum of 600 hours in the previous 52 weeks are eligible for employment insurance to cover maternity leave. Thirty six percent of mothers who have newborns go back to work within two weeks of giving birth (Findlay and Kohen, 2012, p. 6). The present situation of higher income white women more likely to sustain breastfeeding is a reversal of the cultural meaning and social value of breastfeeding held in the past, when it was associated with wet nurses, rural and Indigenous women, black slaves and the urban poor.

Eni and Phillips–Beck reported in 2014 that fewer than half of First Nations mothers initiate breastfeeding (p.203). Many more Indigenous women may not have access to family or cultural supports, particularly if they are evacuated for childbirth from their communities, especially in the North, to give birth in southern hospitals. Indigenous women may experience the medicalization of birthing and breastfeeding differently based on the impact of residential schooling,

[1] SUN and HSAS unions have clauses that accommodate workers who breastfeed.

intergenerational traumas, and sexual abuse. Settler society tends to perceive First Nations teen mothers as the conduit for the high rates of poverty that exists amongst Indigenous population (Fonda, Eni and Guimond, 2013). With limited opportunities to escape the poverty cycle due to lack of education necessary to secure well-paying jobs, these women are "doomed" to live on welfare, a legacy that they, in turn, bestow on their children. Public attitudes to Indigenous pregnant teens as a reflection of "cultural otherness" normalizes the hardship young mothers face (Brant Castellano, 2013) This vulnerability is then constructed as an economic burden on human services, "deviant" and a "pathological drain" on society in Canada (Fonda, Eni and Guimond 2013).

Other minoritized women may also be unable to sustain breastfeeding due to a lack of resources. Based on a meta-ethnography of eight studies on immigrant and refugee experiences of breastfeeding in a new country, Schmied et al., (2011) reported that the common theme was contradictions and conflicts. A loss of traditional practices, clashes between women's individual beliefs and dominant practices in the new country, along with conflicts with immediate family members can all negatively influence duration rates of breastfeeding.

In reviewing the literature on how to support breastfeeding for socially disadvantaged young women, MacVicar et al., (2015, p.290) found that breastfeeding rates are lower due to losses of "community knowledge," combined with limited access to "expertise and vicarious experiences," which led to the "transgenerational adoption of formula feeding." This loss of social capital at the community level, according to MacVicar et al., (2015) affects community members at the individual level, and in particular, teen mothers in the first seven days after birth. In contrast, many immigrants come from traditional societies where breastfeeding is well-accepted. Accordingly, women emigrating from more traditional societies are more likely to be accustomed to an emphasis on social support and postpartum rituals immediately after birth and through their transitional period (Dennis et al. 2019). In comparing the differences between immigrant and non-immigrant populations and breastfeeding rates, Dennis et al., (2019) has found that many immigrant women had positive knowledge of breastfeeding in their countries of origin because these women had been exposed to the value of breastfeeding as children.

1.3.2. Birth Territory and Support of Caregivers. Birthing and breastfeeding are interconnected through the birthing process (Dumas et al. 2012). Birthing is the physiological beginning of the

newborn infant's biological rhythms functioning outside of the maternal body, and lactation is the maternal body's physiological response to birthing the baby and the placenta. The capacity to breastfeed begins during pregnancy; however, it is the infant's initial nursing, immediately after birth that primes the breast to lactate as a functional organ (Dumas et al. 2012; Moore and Anderson, 2007; Smith and Kroeger, 2010). This action, in turn, provides the necessary biofeedback to the maternal body, which has a positive effect on a woman's milk supply by day four and is predictive of mother's confidence in their milk supply at six weeks (Hill et al., 2005, p.29-30). In contrast, a mother's perception of insufficient milk supply in the first two weeks is associated with a lack of confidence in breastfeeding and premature weaning (Ertem et al. 2001, 545-6).

Regardless of the delivery method, providing conditions for uninterrupted skin-to-skin time between the mother and her newborn baby immediately after birth is necessary for a successful latch (Dumas et al. 2012 p.328), and initiation of breastfeeding within the first hour has been shown to lead to a higher rate of breastfeeding beyond six weeks for term infants (DiGirolamo et al. 2008, p. S45). Synchronization of the timing of infants' first nursing with the biological rhythms of the post-delivery maternal body requires maternity care that is woman-centered rather than task-centered. Thus, for women who intend to breastfeed, the establishment of a woman-centered "birth territory" in the delivery room has been extended to include breastfeeding practices. Defined by Fahy and Parratt (2006), birth territory is the collaborative space that women and their caregiver create to support birthing fully in an instinctive and spontaneous way (p.47). According to Meedya et al., (2015) the term "birth territory" can also be applied to define the space where it is a woman's prerogative to breastfeed "whenever and wherever" (p. 265). This space begins in the delivery room and is central to the maternal dyad in their transition from the third to the fourth trimester (Meedya et al. 2015).

1.3.3. The Ideology of "Good Mothering." As a biosocial practice, breastfeeding is done as a "performance of invisibility," as women engage in behaviors that make breastfeeding fit into a "hostile environment" (Stearns, 1999, p. 321). Breastfeeding in public spaces has been considered a taboo, especially for white middle-class women in North America since the early decades of the twentieth century. This sequestering of breastfeeding women limits the biological and nurturing functions of breastfeeding, as well as women's mobility as they try to integrate breastfeeding into

their daily lives. Bottle-feeding, often synonymous with formula-feeding, is thus presented as a viable alternative, in part because women do not have to expose their breasts in public, and in part because bottle-feeding is introduced as a more convenient way to feed the baby.

Relegating breastfeeding to domestic spaces is a way of constraining women by minimizing their threatening status as maternal figures who are also sexual persons (Hausman 2007). Women are caught between the cultural rules of the "good mother" who is kind and caring but asexual, and "the breastfeeding mother" who is also a good mother since she nurtures her baby, but is also imbricated in sexual discourses that conjure up wantonness and unbridled passion. As such, women may be perceived as "bad mothers" when they breastfeed openly at home (Carter, 1995, p.108) or in public (Davis, 2007), where others feel uncomfortable seeing or hearing a baby nurse.

Closeted in a private space, a breastfeeding mother is further constrained by the heteronormative standards that restrict women to breastfeeding their infants to a maximum of 12 months (Giles, 2004, p. 304). During this time, breastfeeding is an evidence of the "good, maternal body" (Stearns, 1999, p. 308), but beyond this period, it is frowned upon as the baby is now a child. The 12-month maximum divides women between maternal care of an infant and the sexed body of a child. Young ((2005) has attempted to untangle these restrictions on mothers, stating that "the gender logic of Western culture depends on a border between motherhood and sexuality" (p.85). This distinction, she argues, "maps on to the dichotomy of good/bad and pure/impure" (p.86). Furthermore, "this separation creates dilemmas for women who must navigate these contradictions." Young asserts, "it is in our bodies that the sacrifice that creates and sustains patriarchy is reenacted repeatedly" (pp.87-88). Through these reenactments, women become alienated from fully experiencing their potential nurturing bodily interactions with their children.

The maternal becomes the locus of different anxieties and insecurities when navigating the ideology of "good mothering." Good mothering depends on functional bodies that give birth naturally and breastfeed with few problems (Fox and Neiterman, 2015). In general, good mothering is easier for white middle-class women to accomplish since they are less vulnerable to criticism and have more supportive life circumstances than other classes of women (Bobel, 2001; Fox and Neiterman, 2015). At the same time, some evidence suggests that white, middle-class women are more subject to the dictates of" good mothering", and for some professional women,

breastfeeding is another work project to manage the body to fit into middle-class standards of motherhood (Avishai, 2011).

In popular culture, visibly pregnant bodies are celebrated, perhaps as a testament to their fecundity and sexuality. Women whose postpartum bodies are marked by extra weight and stretch marks are often shamed if they do not achieve their "normal" pre-pregnant bodies within a few weeks of giving birth. Fox and Neiterman (2015) found that women generally had negative feelings about their postpartum bodies and that younger women living on low incomes with precarious jobs were more upset about their postpartum bodies than women in more secure positions. Also, the desire to achieve the toned body associated with the bodies of pre-pregnant middle- and upper-class women can set a standard that women can have postpartum bodies that are better than before (O'Brien Hallstein, 2006). The conflict between breastfeeding, healthy body weight, and the "good mother" ideology can lead to a sense of disempowerment. Failed breastfeeding has been associated with depression (Choi et al. 2005), and the increasing rates of postnatal depression, from 13% of women within the first 12 weeks postpartum up to 19.2% in the first year, can definitely have a negative impact on experiences of breastfeeding (Dennis and McQueen, 2009, e736).

The literature on breastfeeding and embodiment remains under-theorized (Stearns 2013). In particular, "the corporeal generosity" of the maternal body as a source of biological power, sociability and responsibility is not well articulated in the feminist literature (Bailey, 2001; Hausman, 2003; Hird, 2007; McCaughey, 2010; Shaw, 2003). In "The Embodied Practices," Stearns, (2013) points to three unexplored areas of embodiment with respect to breastfeeding that warrant further research: The efforts and beliefs of the professionals who help mothers initiate and continue to breastfeed; the dyadic body work of breastfeeding and lactation activism (lactavism); and women's efforts individually or collectively to make breastfeeding a public issue (p. 359). With the ontological view that body and mind are integrated, and that the physical experiences of birthing and breastfeeding can be transformative acts, breastfeeding as an embodied practice is explored in this research project.

This project involved working with six participants of the Saskatoon Mothers' Centre (SMC) who had previously been trained as breastfeeding peer supporters. These women requested an enhancement of their conversation skills to support group participation at the weekly gatherings of neighbourhood women. A research project was planned that involved collective learning and

research. Using participatory action research methodology, the project focused on a series of structured conversations. Women explored their experiences giving birth and learning how to breastfeed themselves. They explored how this knowledge helped them to create a woman-centered safe space at the SMC to enhance their support for other women. In the following chapter, I discuss how participatory action research methodology was used in this iterative exploratory process of skill building. Chapters 3 and 4 include the analysis of the data based on a strength-based approach to the women's reflections of their experiences. The results of these women's experiences and this project provide support for breastfeeding as a social activity that is dependent on creating safe woman-centered spaces to support women's intentions to breastfeed. In Chapter 5, I offer concluding remarks and discuss the implications of this project to support a peer run breastfeeding program for women in a low income neighbourhood.

Chapter 2
Methodology

In a review of research methodologies, Spencer (2008) concluded that a mother's experience of breastfeeding support must be examined within her specific context if that research is going to be useful in understanding the effects of breastfeeding support. This research examined the insights of women in the Saskatoon lowest income or "core" neighbourhood into the relationship of their bodies to their breastfeeding children, and their capacities to support one another in a group setting. The primary focus of this research was to support women who live in the margins to develop their leadership capacities, which in turn, enabled them to support one another.

The research project required careful attention to the dynamics of community relationship building. In this chapter, I explore how the SMC, as a child-friendly women's centre in the core neighbourhood provided the context and resources for this project. The SMC's philosophy, which emphasizes affiliation, collective strength and skill-building, was found to be consistent with feminist standpoint theory, which begins with the premise that women's experience is a source of knowledge. At the same time, intersectional praxis problematizes the concept of women's experience by insisting that race, class, culture and other social relations need to be taken into account. In the first part of this chapter, then, I examine the epistemological assumptions that guided this research. In the second part of this chapter, I examine the methodological assumptions underlying participatory action research, particularly as they apply to collaborative inquiry. In the third section of this chapter, I examine the research process. Through active engagement in peer meetings, a group of self-selected peer breastfeeding supporters explored their experiences of breastfeeding in relationship with other breastfeeding women. They were able to develop an analysis of the ways in which power relations structured their experiences while acquiring a shared understanding of facilitation.

This research project also demanded attention to changes in my relationships to the participants and to the SMC board. These changes required reflexivity practices that included ongoing anti-racism education and self-care. In the final section, I discuss the impact of doing this research on my role as a researcher, as well as some of the limitations posed by the project.

2.1. Epistemology

Personal knowledge is generated through awareness of our bodily senses. Peter Reason (2003) points out that experiential knowledge provides the building of tacit knowledge. Tacit knowledge, as embodied know-how, "arises in the process of living" and is the basis of the development of cognitive action (p.206). Tacit knowledge about breastfeeding comes from the sensory experiences that a mother and baby generate together through skin-to-skin contact at birth (Dumas et al., 2012), and feeding and sleeping together, or "breastsleeping" (McKenna and Gettler, 2016). This maternal sensitivity to their babies' particular needs creates "attunement or synchronization" and is experienced as mutually rewarding (Baker and McGrath, 2011, p.1). Synchronicity involves attention to qualities such as acceptance, flexibility, emotional regulation, and timing to provide appropriate responsiveness (Baker and McGrath 2011, p.3). Tacit knowledge of engaging in this dance of physical and emotional synchronicity is difficult to articulate and is developed through maternal experiences of feeding that emphasize the "fit and hold" needed for comfortable feeding (Douglas and Keogh, 2017, p. 510). According to Polanyi, (1966) "we can know more than we can tell" (p.4).

The biomedical propositional knowledge about infant feeding and the discourse around breastfeeding has disrupted the acquisition of women's tacit knowledge (Apple, 1987). This biomedical model has institutionalized maternal/child separations at birth, a sensitive period for the development of successful breastfeeding and synchronicity of the maternal/child dyad (Dumas et al., 2012). Women's knowledge about breastfeeding has thus become constrained by the structural forces that construct infant formula feeding as normal and breastfeeding as an optional "lifestyle choice." Lack of sensitivity to a woman's need for breastfeeding support as part of labour room practices has implications for community knowledge of breastfeeding as a vital support for infant attachment and food security.

Although knowledge is a "mangle of practice," historically contingent and co-produced with society (Pickering, 1993, p.559), it is situated and constructed within a particular set of practices and values that are linked to power (Haraway, 1988). Feminist standpoint theory is based on resistance to the dominant knowledge that has excluded an understanding of women's everyday experiences and their needs in favor of patriarchal views of femininity (Collins, 2004; Harding, 2004; Mosedale, 2014; Smith, 2004). Standpoint theory is an epistemological stance proposed by

feminist scholars who advocated for a recognition that women are experts about the constraints in their everyday lives. Standpoint theorists seek to recognize both commonalities and differences amongst women, and argue that research and knowledge production must begin with women's experiences in the margins. Some feminists argue that the marginalized have revealing insights into ruling relations (Collins, 2004; Harding, 2004; Smith, 2004)). Similarly, Indigenous scholars argue for an Indigenous standpoint that includes traditional ecological knowledge of the interactions of the physical, human, and spiritual worlds (Foley, 2003; Wilson, 2001). This knowledge can be used to confront the Eurocentric matrix of race, class and gender domination (Collins, 2004). Through participatory discussion, the causes of one's own marginalization can be identified (Collins, 2002; Mosedale, 2015). Collective awareness of the impacts of ruling relations can open the door to the development of collective actions to mitigate their impacts.

Standpoint theory has been critiqued by feminists of colour and by transnational feminists. In the past, feminists represented gender oppression as affecting all women in similar ways. Many racialized women, however, are constrained by the impact of multiple and interacting oppressions such as class, sexuality, ableism, and ageism (Collins.2004; Crenshaw, 1991). Collins (2002) argues that Black women's knowledge is a form of subjugated knowledge. From the perspective of being an "outsider within," grounded in an Afrocentric epistemology, subjugated knowledge is a source of resistance and collective action (Collins, 2004, p.103). This insight, according to Lavell-Harvard and Corbiere Lavell (2006) can be applied to Indigenous women who live in the margins and are particularly aware of the ways in which white, western, patriarchal relations fail to meet their needs and the needs of their children. Taking multiple forms of oppression into account, intersectionality addresses the gender focus of standpoint theory by providing a lens into the complexity of manifold oppressive factors that exist and interact simultaneously.

Since collective conversation and dialogue can lead to understanding structural forms of oppression (Collins, 2002; Haraway,1988; Naples, 2013;), social networks that allow for dialogue about experiences of oppression can be a site where subjugated knowledge may be explored. Social networks in which women feel safe to share stories of their experiences with the transition to motherhood provide women with a reflexive way to make sense of their experiences (Miller, 2005; Staton, 2001). Women need support from other women to make sense of their intensely personal and private embodied transition from being pregnant to becoming mothers within the context of their perceptions of public expectations (Marshall, 2007). Working with standpoint theory through

an intersectionality lens is consistent with participatory action research (PAR) and co-operative inquiry as an ethical approach to doing research with the women at the Saskatoon Mothers' Centre, who are predominately First Nations and Métis.

2.2. The Research Site

The SMC provided drop-in programing at Station 20 West daily Mondays to Fridays. At the Saskatoon Mothers' Centre (SMC), there is active engagement with the SMC board, SMC maternity care coordinators, the host coordinator, and the hosts who run the programs. The SMC was and continues to be supported externally through a collaborative relationship among community organizations, the Saskatoon Health Region Maternal Services, and the Health Promotion Department. As an independent volunteer board, the SMC board is responsible for governance in compliance with its charitable status, the strategic direction of the centre, the fundraising and the grant applications to maintain the organization. Board meetings include board members, program coordinators and interested members.

The program coordinators meet on a regular basis to address the needs of the Centre for grants and the needs of the hosts for support. At the time of this research study in 2017, the coordinator groups included a board member, the Elder, the host coordinator, the sewing program coordinator, the food coordinator, the bookkeeper, and myself as the Health Promotion staff. The maternity care coordinators, subgroup of the program coordinators, included a First Nations doula, a board member, volunteer midwife who was also a lactation consultant and myself as a health promotion and a lactation consultant. The maternity care coordinators organized for funding and delivered the breastfeeding peer training. All of the hosts who were working with the SMC at that time were invited to participate in the 20-hour breastfeeding peer support training. Hosts were given options as to the level of participation they would be comfortable with in the delivery of the program. The options included three different roles; being a SMC breastfeeding safe space supporter during regular drop-in hours, a peer supporter in the breastfeeding program sessions, or a facilitator taking on a leadership role facilitating group discussions. Based on these options, all ten hosts agreed to participate in the training. Eight of the ten hosts took on the peer supporter roles, with one person electing to be safe space supporter and one other person took on the leadership role. After participating in the training, the facilitator with a breastfeeding peer supporter ran the peer support program twice a week, Monday afternoons and Friday evenings.

New hosts were recruited based on their interest in working at the SMC, and their willingness to participate in the breastfeeding peer support program as a peer supporter or facilitator. Training sessions for new hosts were held once or twice a year in subsequent years from 2016 to 2018.

A board member and the maternity care coordinators group also organized for the traditional talking circles to provide a traditional Cree way to healing trauma as it related to maternity care experiences. Traditional talking circles were started in summer of 2016, with the first traditional talking circle intentionally planned to coincide with the Equinox in June. These talking circles were held on a quarterly basis, coinciding with season changes. These ceremonies were an opportunity for host and breastfeeding peer supporters in training to meet with a small number of invited Saskatoon Health Region maternity care management staff that included the director of maternity services. Protocols for the talking circles began with introductions and an informal potluck supper. The group then moved to another enclosed room where protocols for gift giving of tobacco to the Cree Elder was followed by prayers and smudging. The Elder initiated the talking circle with participants commitment to adhere to the ground rule that what is said in the room stayed in the room. The Elder facilitated the three rounds of talking with these questions: What brings you here? What would you like to share with others? And, what will you leave with? A talking stone was used to ensure that the space for each speaker was held sacred. The Elder provided the talking stone to the person on her left and this order of speaking continued around the circle. With the talking stone in hand, the speaker had a choice to pass or to speak for uninterrupted time. This opportunity of sharing personal stories included the emotional trauma encountered during childhood, and during the transition to adulthood that encompassed the experiences of pregnancy and birthing. These traditional talking circles continued with hosts and health professionals until the summer of 2019. In this way, the board worked with the coordinators and the hosts to develop and support a safe, strength-based culture that validated the women's experiences.

The request for a facilitation learning project came to the maternity care coordinators from a host meeting held at the end of June 2017. A number of hosts specifically stated that they wanted more facilitation skills that would move them from peer support, that is based on one-to-one conversations to peer leadership roles where they could facilitate group conversations. This project was organized as a potential PAR project in September 2017. The proposal was taken to the Board for discussion and was approved on 30 October 2017. All 10 hosts were invited to participate in

facilitation training. Six hosts agreed to engage in a group-directed research project to develop their facilitation skills: Sarah, Jasmyn, Kyla, Della, Rahilah, and Ferdousi. They were not interested in using a pseudonym, rather they wanted to share their given names in this thesis. Sarah, Kyla and Della are First Nations women who all grew up in and around Saskatoon. Four of the women, Sarah, Jasmyn, Kyla and Ferdousi were similar in age, all in their 20s whose children ranged in age from infancy to elementary school age during this project. Rahilah and Della were in their 40s with older children who were in middle to high school. Sarah is a First Nations Salteaux woman from the Kinistin Reserve near Melfort. She grew up with her First Nations father and her white mother in Saskatoon. She is a single mother of four boys aged 4 to 13. Kyla is a Status Indian from Mosquito Reserve near North Battleford, and identifies as a '60s scoop child who grew up in a white foster home in Warman. She is a single mother of two boys, with her youngest child in her care. Della is a Cree First Nations woman from Day Star Reserve near Punnichy. As a 17-month-old toddler, Della was removed to a foster home in Saskatoon with her twin sister. Della is in a long-term relationship, married to the father of her of two sons. Jasmyn grew up white in Saskatoon and came to recognize her Métis background through her association with the SMC. She was a single mother who married the father of her second child. Rahilah and Ferdousi are both immigrant women. Rahilah was born in Kabul, Afghanistan, and emigrated to New Delhi, India as a teenager in order to attend university. As a divorced mother of two sons, she emigrated again in 2005 to Saskatoon to be with her mother and brothers. Her third child, a daughter, was conceived in India, born in Saskatoon. Ferdousi was born in Sylhet, Bangladesh and emigrated in 2007 to join her arranged marriage partner who lived in Montreal. They moved to Saskatoon a year later where she gave birth to her only child, a son, in 2009. Ferdousi separated from and divorced her husband during this project. All six women became aware of the SMC through their association with Saskatoon Health Region community programming for families that included Midwifery Services, Healthy Mother Healthy Baby, Food for Thought, and Kids First programs.

2.3. Methodology

Participatory action research is a method that involves co-operative inquiry at the community level. Co-operative inquiry is a collaborative inquiry method based on sharing stories with others through relationship-building in the context of those who share similar interests and concerns (Reason 2003). The goal of co-operative inquiry is to solve practical problems in the community with a

focus on shifting the balance of power in favour of those who are marginalized (Reason 2003). Co-operative inquiry also supports Indigenous ways of doing research as this method aligns with the values of Indigenous relationship-building (Wilson, 2001) when it involves the wider community and has a primary goal of "resistance to racialization" (Foley, 2003, p. 48). The hosts trained as breastfeeding peer supporters and participants of the peer support program were invited to tell their birthing and breastfeeding stories in talking circles. The talking circles, led by an Elder working for the Health Region, have evolved as a safe space for these stories to be heard in ways that can promote both a learning and a healing process. These talking circles are structured to be a mutually collaborative reflection process with maternity care staff and health region managers. However, it was hard to know how these stories influenced the peer support group individually or collectively. Being more intentional about process and including reflective practices after each talking circle provided a knowledge base for the development of facilitation skills and collective agency.

Co-operative inquiry rests on two participatory principles: epistemic and political participation (Heron and Reason, 1997). From an epistemic perspective, one of the primary purposes of co-operative inquiry is to address the disconnect in modern thinking that places humans apart from nature (Reason, 2003). Participation is also political; it is a way of supporting people's rights and capacities to inquire into and make sense of their world and to have a say in decisions that affect them (Reason, 2003). Co-operative inquiry is a skill-building process (Heron 45) that engages emerging capacities of self-awareness and self-direction (Reason, 2003). Self-development is key to the reframing processes needed for understanding diverse perspectives of one's experiences that can lead to more openness to others and can assist leadership in service of others (Reason, 2003). The peer supporters' request for learning facilitation skills thus supported their motivation for engagement and reflections.

The SMC peer support program has the resources for this type of inquiry work that includes space for meeting, childcare, and food for the focus groups. The co-operative nature of the SMC has helped the hosts in developing communications skills and conflict resolution based on the practices in the book, *Nonviolent Communication*.[2] This communication practice supports building skills in non-dualistic thinking. Collins (2004) points out that the construction of dualistic thinking, either/or, may be the "linchpin in systems of race, class and gender oppression" (p.110). Since the

[2] Rosenberg, M. B. (2003). *Nonviolent Communication: A Language of Life*. Encinitas: Puddle Dancer Press.

inception of the Centre, a bi-monthly book club session has been held based on this book for hosts and participants. The book club is facilitated by an internationally-trained facilitator who works with the women to articulate their observations, feelings, and needs. In addition, there are resources for the women who are dealing with the trauma of their birth and breastfeeding experiences. Having an Elder participate regularly in maternity talking circles was one way to provide that support. Tara Turner, a psychologist, provided additional support at all these talking circles.

This development process for SMC hosts was supported by creating a learning space for dialogue about their knowledge, where the hosts could share their reflections about their participation in the talking circles. This dialogue offered opportunities for the women to share their stories and to question maternity care practices that they experienced. These conversations provided the women with a larger framework for viewing their own stories and potentially led to a reframing of their own experiences. Hosts who participated in this dialogue could then enhance their skills in listening for and responding to the maternity care stories that impact other women's embodied experiences of birthing and breastfeeding.

The principles of the SMC are based on a bottom-up approach, and hosts determine how to create a safe space for women and their children through team meetings. Through personal check-ins at each of the team meetings, the women and I shared what we were dealing with in our daily lives, supporting non-judgmental relationship building. These conversations were further supported with *Nonviolent Communication* book club gatherings. The women developed a collective sense of the impacts of marginalization through reflective practices in the facilitation training and in participating in the talking circles. These conversations led to critical analyses of the impacts of marginalization on Indigenous mothers, patriarchal prescriptions for mothering, and the medicalization of birthing and breastfeeding. The participants also came to recognize the importance of embracing breastfeeding as a part of their cultural traditions, which were seen as a resource for food security, and individual and community empowerment.

One measure of success in this process is the interest that the participants had in joining a program for facilitation skills development. All six participants who started the training stayed with the SMC and contributed to leading the weekly mothering talking circles. In turn, they mentored a new group of peer supporters. The findings of this study demonstrate the efficiency of a PAR methodology to document the impact of peer support with a group of women in the margins. PAR supports worked with the community to explore and provide a voice for the identified issues.

The SMC board provided support for the development of the facilitation project and formally approved this study as a research project in October 2017. Board members also provided psychological and cultural supports and protocols for the project. Conflict did arise when a member who joined the SMC board after this project had started suggested that this research project was another form of colonization. Fortunately, with the support of the other board members this conflict was resolved and I was able to complete the research project.

2.4. The Research Process

Participatory action research as a community-building process uses a strength-based approach to building relationships. Likewise, the SMC is built on a strength-based approach. Marginalized women are seen as capable and resilient in the face of multiple challenges. This approach to women as resourceful agents was used to engage participants in a joint learning inquiry process. PAR method supports working with the community to explore issues arising within the community. The participants thus became active subjects in the research process rather than objects to be studied. From the beginning, the participants became co-researchers. To identify the issues, however, ongoing respectful relationships needed to develop between the board members and the hosts. The various parties in this research worked toward Indigenizing the SMC by adopting First Nations and Métis values of mutual responsibility and reciprocity as the foundation for the relationships, which was achieved by following protocols, ceremony, and the creation of talking circles (Wilson, 2001).

The engagement method of PAR had four distinct phases of a learning cycle (Reason 2003). These phases flow from nurturing, to interactions, to accomplishment, and then to relaxation. The nurturing phase builds relationships in an emotional climate of safety; the interaction phase builds momentum for the dialogue; the accomplishment phase involves the recognition of what has occurred in the learning and the relaxation phase becomes the time for reflective supports and closure to a cycle of inquiry. This method is a practical process of inquiry that the women who run the breastfeeding peer support program already use in their facilitation of weekly sessions and talking circles. It is an iterative process built on incremental changes.

PAR was an appropriate method to ask deeper questions about the experiences of the hosts as breastfeeding peer supporters. PAR follows a quality improvement learning method that involved a “plan-do-study-act cycle” (Taylor et al. 22014, p. 90) and is consistent with the ways

in which the hosts approached changes needed to improve services to participants. There were four phases in this research. As an observer participant, I kept brief notes in my day book during sessions, which were reviewed after to support the process of engagement and skill building. These notes help support the next steps in the iterative process of collective skill building. Journaling was used to support reflexivity processes that came after the sessions and were useful to record interactions and remarks that surprised and/ or confused me.

Phase 1: The planning phase began on September 6, 2017. The maternity care coordinators and the six hosts who had agreed to participate attended a joint meeting to discuss the learning process since the research project would eventually generate a report back to the SMC Board and the funders. A meeting was held later that month in order to explore with the hosts what they intended to learn through the facilitation training process and how they would participate in the research project. An important question considered was, "what will the women gain by participating in the research project?" A draft outline of the research process was discussed, as well as the consent process. This planning included how the group would participate in developing the questions for the focus group, the data collection methods, as well as roles for participants. As the lead researcher, my contribution to this initial meeting was to provide organizational inputs to coordinate and facilitate the discussion. I recorded the decisions made at this meeting and drafted the proposal for the SMC Board's approval at its meeting held on October 30, 2017.

Phase 2: The action phase of the research began on November 9, 2017. The inquiry work started with the Novemeber group planning meeting, and ended on April 2018. The group agreed with using a co-operative inquiry method based on the plan-do-study-act cycle[3] that they were familiar with. These sessions were built around three agreed upon objectives: 1) to learn how to use the plan-do-study-act cycle to enhance facilitation skill; 2) to enhance a mother's support network to help her achieve her breastfeeding goals; and 3) to provide inputs into the evaluation report for the funders. Based on the participants' inputs, learning and questions, four training sessions were set up. They included developing a list of facilitation skills that the group identified as important to learn, along with an ongoing review of what we were learning together. In one of these sessions, the Almeling's Russian Doll metaphor was used as a visual aid to deepen the conversation to women's awareness and understanding of the biological and social processes

[3] Women were familiar with PDSA cycle as this was used in their team meetings as a way to build consensus on problem solving concerns they encountered and raised about the operation of the Centre.

embedded in their stories and the stories of others. This exercise led to conversations about the impacts of colonization.

In the sessions on developing facilitation skills, the participants learned a variety of techniques to help empower other women. They learned the importance of positively responding to the opening of conversations; assuring the mother she was not alone in her situation; using open-ended questions and listening skills; attuning to silences; and understanding the importance of positive feedback. The skills were practised in sessions organized with the new hosts who were attending the breastfeeding peer support training. In addition, the participants were provided with opportunities to do written self-reflection at the end of each meeting and to share collectively what they were learning. This collective dialogue helped participants identify their capacities for curiosity, imagination, and reflection. Utilizing the planning, do study and act cycle with the hosts were familiar form their team meetings, this project as a group-initiated project represented another step in the SMC host engagement. During these meetings I kept notes of the main ideas that came forward on a whiteboard in the room, which was then photographed. These ideas were later reviewed in the following session.

I conducted six individual semi-structured interviews from January 2018 to March 2018. Interviews were held at this stage as a way to build relationships with the participants and to better understand their context for learning theses skills. The three questions, "the story of you, the story of us, and the story of now" that were agreed to in November were repeated. These questions were borrowed from Marshall Ganz's "What Is Public Narrative,[4]" a public storytelling model that supports connecting "heart, head and hands" for the purpose of building meaningful relationships, and connecting values to action. These interviews also referred back to the Russian Doll metaphor used in the facilitation sessions to deepen the conversation to women's reflections on the biological and social processes embedded in their own stories. See Appendix D. Each interview lasted about an hour or more with the exception of Della's interview which lasted 30 minutes. The transcription of interviews was provided to each participant to review and correct. Further interviews were conducted individually with Sarah and Kyla to clarify their experiences of racism and marginalization as teen mothers.

[4] Ganz, M. (2009). "What Is Public Narrative: Self, Us & Now" (Public Narrative Worksheet). Working Paper.

Phase 3: The Study Phase. A focus group using a talking circle format was held on 16 November 2017 and was repeated at the end of the training on 30 April 2018. A SMC board member, Tara Turner, provided guidance to these focus groups which took the form of a talking circle. An iPhone was used as a talking stone to support each individual to have the space they needed to respond or not to the questions in a safe environment. These remarks were recorded on the iPhone and transcribed using the *Transcribe* application. The culminating talking circle happened in April 2018. This session allowed the group to process their experiences based on repeating the three previous questions with an additional question; how does this breastfeeding peer facilitation work matter to the women we serve, to the community, and to you?

Phase 4*: I* conducted an initial data analysis through NVivo, a qualitative data analysis software program. NVivo organizes data for key words and phrases, trends, and insights, and provides ways to make comparisons with different aspects of the data. The codes were further organized using Almeling's conceptualization framework of reproduction as both biological and social phenomena Using this framework, the data was coded based on the women's experiences of their bodies in pregnancy, birthing and breastfeeding, their interactional experiences with others during this maternal time, and their experiences of structural and cultural supports and barriers in their intentions to breastfeed. Once the initial codes were established, themes were generated from the data. The participants were invited to meet on June 17, 2018 to discuss the themes generated from data. Participants felt that the categories covered their discussions adequately. It was at this meeting that they discussed the need to consider making a change to the bi weekly breastfeeding sessions to include women who were not breastfeeding.

2.5. Sources of Data

This project was based on multiple sources of data. The main source of data were voice recordings and transcriptions of the focus group session held before and after the facilitation skill building study period. In addition, I kept meeting agendas and notes for the planning session and for each of the four the skill building sessions. In order to maintain accuracy of what transpired during these sessions, I took photographs of the white board that recorded the facilitation skills the group wanted to work on. I also kept my own participatory/observer data in a daybook and used journal entries to support my development as a non-indigenous person working across the cultural and social divides.

2.6. Data Analysis

The data analysis was based on Carol Gilligan's (2015) Listening Guide Method of Inquiry, which employs listening to different aspects of the narrative including, but not limited to, the plot; tracing the story and the construction of the self-beliefs; the different voices used to tell the story of self in relationships with others and the construction of power dynamics that frame the narratives. With these different readings of the data, the researcher composes an analysis or an interpretative framework for the narratives. The analysis process was discussed with the participants when clarification was required. Not fully understanding Kyla and Sarah's experiences as indigenous teen mothers, I arranged with each of them to go over their interviews and ask for additional information. Using this research method, the researcher is an active agent, requiring that I, as the researcher, be reflexive throughout the process and sensitive to the power relationships involved in the interactions. This was particularly important in understanding the challenges these women had dealt with as young teen mothers having their first child.

2.7. Ethics: Working Towards Development of Ethical Space and Respectful Relations

The Saskatoon Mothers' Centre attempts to create a culturally-safe space for First Nations and Métis women, but it is also open to others, including immigrant women. The SMC is a woman-only site that supports a bi-weekly breastfeeding peer support program. As part of the research team, I needed to clarify my participatory observer role in this reflective process. I aimed to attune to assumptions that come from my role as a health region employee, as a community development worker with the SMC, as a nutritionist, and as a lactation consultant. I acknowledge my insider/outsider standpoint as a researcher. Having worked in the SMC since its inception, I share insider knowledge with these women of the formal and the informal organizational aspects of the SMC. As a mother and lactation consultant, I am aware of both the power and the vulnerability that is present in the transitions that happen in birthing and breastfeeding. I also share an empathic understanding with the immigrant women who come to the SMC because my family immigrated to Canada from the Netherlands as part of the federal government's post war policy to expand farm labour capacity. Therefore, I can relate to ongoing difficulties with literacy and issues with cultural interpretation. I learned to speak English as a school aged child through interactions with my peers in a German Catholic settler community. These experiences of being an outsider provided me with an understanding of different ways of knowing. I take Collin's (2004) positive interpretation of

this location as a call to attention, to trust my biography as a source of knowledge and to fully occupy the space it generates for different ways of seeing, listening and understanding.

My outsider knowledge also comes from my position as a non-Indigenous middle-class white woman. I have benefited from the privileges attached to being a professional health care worker engaged in union-supported full-time employment. I needed to recognize this outsider position as a source of both conscious and unconscious bias. It was necessary for me to better understand how I occupy a contradictory location in relation to the Frist Nations and Métis women who make up the majority of the participants. Teusner (2016) and Ryan (2005) argue for reflection and reflexivity as key strategies to make visible the methodological and epistemological assumptions made in the research processes.

Working at the SMC has meant an ongoing commitment to relationship-building and reflexivity. My lack of knowledge of how I embody colonization and white superiority meant I needed to address the ways in which whiteness and colonization intersected with my gender, education, professional status, and class position at the SMC. I needed to recognize my own privileged position in a different way and to understand my own discomfort working with women and children who have been marginalized as deficient and who dealt with intergenerational trauma. I had to find my way as a facilitator to embrace a strength-based approach that challenged my professional assumptions and unconscious racist biases. The facilitation project required me to embark on a personal journey to learn how to deal with the impact of colonization and racialization on this research project.

There were challenges along the way. I found it difficult to hear women's stories of hardship and their experiences with structural and institutional violence and lack of resources. Through journaling and writing about specific incidences, I was able to examine my feelings, assumptions and biases, and to understand my white cultural motivation to evade responsibilities through "moves to innocence" (Tuck and Yang, 2012, p.1). I now understand this "move to innocence" as a way to evade my feelings of guilt for my unearned privilege. My relationship to the participants of this research project required on ongoing reflexivity and anti-racism education. This iterative process allowed new questions and insights to emerge. It provided the opportunity for a mind shift in a conscious way to move from feeling 'responsible for' to being 'responsible to' the women and the SMC board in a more intentional way. Being of service to the women in this project opened the door to understanding the differences between empathy and compassion

which was a way to pragmatic solidarity. Conscientious care and accountability to the participants and the SMC board led to opportunities for relationship building in sustainable ways.

Germaine to this process is my understanding of historical relationships with First Nations and Métis peoples in Canada. Readings help me understand the accumulation of unearned power in my position that come from my white privilege (McIntosh, 1988; Sullivan, 2014), and my white immigrant settler status (Lowman and Barker, 2015; Datta, 2019). I reviewed resources to deepen my understanding of structural racism in health (McGibbon, 2018) that impacts my professional health care worker status as well as my role as a university student and feminist researcher (Opie, 1992). My emotional responses and actions are to reposition myself as a potential ally, as Bishop defines it, and to leverage these understandings towards system changes. Conversations with SMC board members, Marjorie Beaucage, Tara Turner, the Elder Judy Pelly, and Sarah Cochran Smokeday provided me with opportunities to clarify my learnings. I have taken an 800-level class from Rose Roberts on Colonization and its Impacts on Indigenous Health and Healing at the University of Saskatchewan. I have participated in ceremonies including a round dance, sage gathering, moss bag making and a sweat. I continue to support my ongoing learning through regular participation in Saskatchewan Indigenous Birth Network and Saskatoon Anti-Racism Network gatherings.

This research project followed the Tri-Council Guidelines, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS). An ethics application was submitted to the University of Saskatchewan Behavioral Ethics Board. The Saskatoon Mothers' Centre Board submitted a letter of support for this project. This consent is consistent with the University of Saskatchewan criteria for ethical engagement with Indigenous peoples. Informed consent of individual participants was obtained prior to the initiation of the research project. Consent included a discussion of the details and the potential risks of participating. The SMC board was a resource in providing traditional ceremony and protocols to do this research. Since the research was implemented in distinct phases, each phase provided an opportunity for the SMC board and the participants to decide whether or not they were willing to participate. The SMC board, as well as individual participants, had the right to withdraw from the project at any time with the caveat that the participants and the SMC discuss the consequences (U of S Ethics Board). Ethics materials can be found in Appendix C.

2.8. Limitations of This Study

This study was limited by the size of the sample (six women) and the self-selection process of the participants who had the time to commit to the study. Some women at the SMC who might have participated may not have felt safe enough to take on the challenge of becoming a facilitator and participate in a leadership role, which they probably perceived as intellectually challenging (field notes). Also, the time in implementing the study may have deterred some women from participating as it took six months after the women had asked for facilitation training to organize the study proposal, and gain consent of the SMC board and the University of Saskatchewan. Had the project started when they requested, the project may have engaged a different group of women.

This study occurred in the SMC, which is a space limited to women of all ages and to their children. This space is further restricted in that it does not accommodate men or boys over the age of 12. Grandmothers do attend the Centre, some of them in their capacity as board members, or Kokums and others as grandparents who continue to parent their own children or their grandchildren. However, this study was limited to breastfeeding peer supporter, and at the time of this study, there were no grandmothers in the peer support program.

Two of the participants whose first language is not English struggled to describe their experiences and to express what those experiences meant for them. The fact that the focus of the research was on birthing and breastfeeding may have deterred the participants from talking about other issues, such as the impact of marital relationships, body image, or public barriers to breastfeeding such as using city transportation with a breastfeeding child. As a result, the findings of this study cannot be generalized; the women who did not participate may have different views about the embodied nature of breastfeeding in the context of their lived experiences.

My role as the researcher may have affected the stories that the women told. The skill development for facilitation, which was the basis of this research project, was limited to planning and the support I could bring to this work. I am a nutritionist by training and a lactation consultant; my training as a facilitator is limited. The Health Promotion (HP) community developer on the SMC project retired at the end of 2016. As the sole Health promotion worker responsible for the SMC facilitation project, I found that the increased work load affected the timelines for the facilitation training.

Chapter 3

Choices and Commitments in the Face of Hardship

In this chapter, I discuss the analysis of the participants' stories of their births and breastfeeding experiences. Despite their intentions to breastfeed, the women faced many challenges in initiating and sustaining breastfeeding. These factors ranged from economic hardship, postnatal depression, the stigma of being a racialized pregnant teen, having a life history of trauma and violence, and for the immigrant women included learning how to navigate a medical system without a sense of competent cultural knowledge and language skills. Nonetheless, some of the women were successful in breastfeeding their children. The factors that contributed to this accomplishment were related to the way they stayed connected to their intention to breastfeed and the way they utilized their internal resources to integrated their breastfeeding relationship into their lives.

3.1. The Intention to Breastfeed

Maternal commitment to the child is voluntary and conscious (Ruddick, 1989). It is not inevitable nor is it dictated by nature. Ruddick explains "both maternal work and the thinking that is provoked by it are decisively shaped by the possibility that any mother may refuse to see creatures as children or to respond to them as complicated, fragile and needy" (p. 22). A woman's commitment to being pregnant hinges, in part, on the access to emotional and material resources needed to take on the responsibilities of caring for a dependent child (Ruddick 1989). Women ultimately face a point in time where they become fully aware that they are pregnant and can make a conscious choice in continuing or discontinuing the pregnancy. Although discussion of pregnancy was not central to this breastfeeding research project, the participants' experiences of pregnancy shaped their views of the changes that they could anticipate and their awareness of the economic, social, and emotional resources that they would need to raise a child.

In the case of breastfeeding, the material and non-material conditions support the mother and infant during the postnatal period that has been termed the "fourth trimester" (Tully et al. 2017, p.37) when mother and infant become a 'mutually dependent unit.' During this time, mothers become experts about their infants through developing a "deep psychobiological connection" (Tully et al.2017, p. 40) which builds a "trustful reciprocal mother infant bond" (Flacking et al., 2006, p. 70). For breastfeeding women, the fourth trimester starts in the labour room, immediately after birth in which the infant initiates breastfeeding, and continues during

the two to three-month period for lactation to become fully established. This learning period, or the "breastfeeding-bonding trajectory" (Kronberg, 2015, p.82), is composed of three overlapping phases for first-time mothers. It begins with the mother being on shaky grounds, when breastfeeding can be painful, and women deal with conflicting advice. This initial encounter is followed by a period of time when women are struggling for a foothold, trying to understand breastfeeding, their infants' feeding cues, and finding professional advice to reaffirm their decisions. The final phase is being at ease with their breastfeeding decision, feeling capable to care for their infants with a sufficient milk production that satisfies their infants' needs.

3.2. Factors That Influenced the Continuation of Breastfeeding

Factors affecting breastfeeding choices are multiple and varied. Financial barriers, stigma around racialized teen mothering, experiences of violence and trauma, and caregivers' support, or the lack thereof, play a major role in breastfeeding initiation and duration.

3.2.1. Economic Hardship. Discussions of personal income and finances are often considered to be taboo subjects, and asking research questions about these matters are often deemed intrusive (Tourangeau and Yan, 2007). In this study, personal finances were ascertained indirectly. In casual conversations, participants discussed single parenthood, housing and income issues, unexpected financial difficulties and the women's sense of food insecurity. These issues were noted as indications of economic hardship.

None of the study participants had access to full-time employment although some had a variety of seasonal and part-time jobs where they would make minimum wage or slightly more. Four of them spoke of experiencing financial difficulties related to being single parents. Financial hardship came in the form of unexpected bills including the costs of marital separations, housing issues, high water bills due to plumbing problems, theft and vandalism, car breakdowns, accidents and repairs, loss of eye glasses, child tax disputes with the Canada Revenue Agency, and out-of-town family illnesses and funerals. Unexpected financial difficulties, which became emergencies, were a common challenge for all six participants. These unforeseen costs were framed as stressful challenges to family resources where there is no back pocket to draw from (field notes).

Single parenting on an income below the poverty line is parenting under duress. Any single, unattached adult, living on their own in Saskatchewan and working full-time at minimum wages

is living below the poverty line (Stevens 2017). If the adult is a single woman who becomes unintentionally pregnant, she faces a potential crisis. Without adequate financial aids through maternity leave benefits, a single woman can be pushed further into a poverty cycle that is difficult to overcome. Although only one woman in this study started her first pregnancy as a single person, four of the women became single parents at some point after the birth of their children and were single parents during this study period. As a single woman working as a restaurant server, Jasmyn's income was precarious. Salaries in the restaurant industry are based on minimum wage, which are supplemented with discretionary tips and varying hours of work. Her unplanned pregnancy precipitated an emotional crisis based on her ability to commit resources to herself and this pregnancy;

> I wanted to grow up and be an artist and live in a loft, [ ][5] I know it's what I wanted; anyway, and then I got pregnant with Teagan unexpectedly and it was generally very, very difficult because she was an accident and I was living in BC and then it was just well, honestly, I'm not a hundred percent sure who her father is…I wish I was just in a different place… [ ] I'm living on my own, having fun, you know, and it just kind of happened as an accident. I was drinking you know … condom breaking that kind of thing… It was a rough go at the beginning of the whole pregnancy. It was quite rough cuz I remember [ ] lying awake at night crying because I didn't want to do it but it happened. I wasn't ready. The prenatal education was very scary. I was scared for the birth, you know, that whole thing [ ] well there's more, difficult still, [ ] it's still difficult. It's still difficult.

For Jasmyn, her first pregnancy was a disruption of her new-found independence, a chance to experience adult life, to be responsible for herself and the potential it held for her aspirations as an artist. Her pregnancy was not planned and the uncertainty of her child's paternity meant that she could not count on these resources to help her during pregnancy and motherhood. Jasmyn was unprepared for being pregnant; indeed, she would rather not have been, leading to sleepless nights

[5]A parentheses [ ] is being used here and through out the quotations in this thesis to replace the word "like." This editing has been done to facilitate ease of reading. Removal of this type of figure of speech is debated in the literature since it may denote the speaker's hesitancy (Corden and Sainsbury 2006).

and bouts of crying. She was left struggling with the consequences that this sexual encounter would have on her life. Despite these difficult circumstances, Jasmyn's commitment to motherhood can be seen through her positive actions to take prenatal classes. The classes did not, however, stem her fears of giving birth. Her repetition of the phrase "still difficult" suggests that she continues to be left with the problems associated with the life choices that she has made to have her daughter and continue to live with limited financial resources.

Financial hardships translated into other "hidden injuries of class" (Sennett and Cobb, 1972). Food insecurity is a growing problem in Canada, where one in eight households deal with uncertainty in food access (PROOF, 2020). In 2014, women-led households with children under 18 were the most food insecure; 33.5% of these families dealt with compromised intakes that ranged from marginal to moderate to severe food insecurity (Tarasuk et al., 2014, p.11). McIntyre et al. (2003) have argued that women living in poverty often preserve their children's nutritional health by compromising their own.

At the SMC many of the women were dealing with food insecurity in their own homes. When the conversation turned to food security in the talking circle, Della recalled that she would give the milk to her sons because it was nutritious, but she would deny it herself because it was expensive.

> I used to reserve the milk when my boys were younger; I used to reserve it for them because back then I was like you know for a jug you know how much it is today and back then it was just as expensive and so I would reserve that for them because I knew it was good for them because they were little and you know they needed that nutritious milk and I didn't indulge in that because I reserved it for them and you know I had to sacrifice as a mother.

Mothers who deal with household food insecurity pay a price and have to cope with their own unmet needs that can undermine their feelings of dignity, agency and competence as parents. Issues with food insecurity were evident at the SMC through the interpersonal tensions that were observed about resource allocation. In order to create a sense of community, nutritional snacks were provided to participants at each session. However, particularly at the beginning of developing the drop-in program, a host might help herself to the food that was intended for the participants, leading to tensions of blame and shame among the hosts (field notes). The problem, as it turned

out, was that some of the hosts who came to work a shift at the SMC were hungry, particularly if they were pregnant or still breastfeeding. As the women became comfortable with discussing hosting issues at team meetings, they recognized the need to preserve the food for the drop-in participants. This issue also became an opportunity to address the expressed need to provide more substantial food at the breastfeeding sessions that the hosts could share with the breastfeeding women who came for support. The emotional tension around food resources in the centre is an indicator of the effect of poverty on the human right to food security in the lives of women-led families.

3.2.2. Dealing with Stigma of Being a Racialized Teen Mother. The stigma of irresponsible sexual behavior is often applied to teenage women generally, and particularly to First Nations and Métis women who are often "pathologized." In this study, two of the women, both First Nations women, had their first child as 17-year-olds, and both were affected by the stigma of Indigenous teen pregnancy. This issue was so powerful for Kyla that she had difficulty talking about it directly. Nevertheless, she said: "My self-identity, [ ] was really tried to [ ] being a good mother. I like try to protect myself with that overly [ ], you know, concentration on my parenting skills." Identifying with the image of a good mother was a way of defending herself from the stereotypes of Indigenous teen mothers. Kyla needed to distance herself from the stories of her mother who also was a teen mother dealing with child removal and her own history as a 60's scoop adoptee and sexual abuse survivor. What was most troubling for Kyla was to find the cycle repeating itself: Her white adopted mother, a woman dealing with infertility issues, had pressured Kyla's biological mother as a teen mom to give Kyla to her, then in turn she pressured Kyla to voluntarily give up her first-born child at nine months. Partly in response to this strain, Kyla was very active as a peer supporter at the SMC and led the discussions about ways in which to keep the SMC a safe space for young mothers. Through these discussions, she initiated the development of a large sign that was put up in the entrance of the SMC, stating that the Centre was not associated with Social Services.

In contrast, Sarah was very open about the negative impacts of being represented solely as a teen mother. Her first visit to the doctor's office left her "feel[ing] awful." The doctor asked questions about Sarah's partner, and why he had not come with her to meet with the doctor. Despite the fact that her partner was working in British Columbia and earning an income, the doctor suggested that he was irresponsible and his lack of dependability would be a problem for Sarah. Additionally, the doctor indicated that she needed to finish her education, perhaps implying that she should have an

abortion. If not, the doctor intimated that she would be repeating the cycle of poverty by saying that "you can only expect as much from your child as you have achieved." Not surprisingly, this strategy of shame and blame left Sarah crying. Luckily, however, Sarah was made aware of community resources through the childcare nurse at the alternative school that she was attending to finish her grade 12. By attending those prenatal classes, Sarah realized that her Indigenous and teen status was problematic in this educational space. Like the other teen mothers in the class, Sarah felt judged by the older, white mothers who were already established in careers: "We felt as though other parents thought we should not be having this baby because we were not finished school."

As a First Nations teen mother, Sarah was subjected to racist comments from some of the fathers in the prenatal group as she sought answers to questions about aspects of breastfeeding, circumcision, and returning to school. For example, following a question about the safety of drinking a glass of wine and breastfeeding, Sarah then asked a question about drinking beer because she had heard that it could increase milk supply. A father in the audience answered, "go ahead and drink a whole lot as clearly that is what you want to do." In response to her question about breastfeeding a newborn and returning to school, another father in the class implied that she would be a "bad" mother since she would "not [be] taking time to be with [her]baby." In these situations, Sarah found herself in a no-win situation; she was criticized because she had not completed high school yet when she indicated that she wanted to return to school, she was criticized for not being a more "dedicated" mother. Her critics ignored the material conditions that allowed her white peers to stay at home to care for their newborns. The lack of resources was made clear when the nurse/instructor suggested that Sarah buy a very expensive manual pump, one that Sarah said she could not afford.

Note that it was the fathers in the group who responded negatively to Sarah's questions. The men took upon themselves to police Sarah's behavior, revealing how racist, classist, and patriarchal microaggressions work in everyday life. In the first two examples, the male observer enacted racist assumptions about Indigenous young mothers, implying that they were not fit to be "good mothers." In the third, the nurse seemed unaware of the financial burden that buying a pump would place on Sarah. In a final example, a father offered a negative assessment of an uncircumcised penis: When Sarah asked about how to avoid circumcising a male child, he remarked that it is "so gross; it looks like squids." This exchange reveals the conflicting cultural meanings of the circumcised and uncircumcised penis. In the last 15 years, there has been growing

opposition to circumcising male infants, identifying it as medically redundant in all but exceptional cases, and causing unnecessary pain. Here, the father's representation of an uncircumcised penis as "gross" and squid-like does not conjure up images of sexual potency and phallic power.

Even though the women in the prenatal group did not engage in these overt forms of racism, neither did they come to her defense. Sarah noted that the body language of the women in the class seemed to affirm these remarks and that the prenatal instructor did not intervene: "[she] did not interrupt theses side conversations; she appeared to lacked control of the class when it [the conversation] went off in this direction." Not surprisingly, Sarah, as a First Nations pregnant teen mother, felt alienated from the group. Her experiences point to the way in which this prenatal class was structured to meet the needs of the women who were older, white, married (or in long-term relationships), and middle-class. An unspoken alliance was formed by the white participants and the instructor which allowed the racist comments to go unchallenged. As a result, Sarah was unable to access the information and services she needed in a respectful way. These examples, as well as the doctor's judgement about Sarah's youth, reveal how First Nations pregnant teens are constructed as "pathological" or as "bad mothers;" they are represented as ignorant, non-compliant, and therefore conform to the stereotypes held by many health care professionals. In addition, these examples demonstrate the ways in which patriarchal authority, whiteness, and class privilege work to perpetuate inequities in service provisions.

3.2.3. A History of Violence and Trauma. A history of sexual abuse can negatively impact prenatal care. Research has demonstrated that the effects of childhood sexual abuse can lead to compromised prenatal care as bodily changes and interactions with health care professionals can trigger unresolved trauma (Leeners et al., 2010). All six research participants experienced violence and trauma within their families: two were 60's scoop survivors[6]; two had experienced domestic abuse; two had experienced sexual abuse in the family home; and one who had experienced domestic abuse also dealt with political unrest and war in her homeland of Afghanistan. For the most part, the women did not elaborate on their feelings about violence and trauma directly and their effects on their experiences of pregnancy or birth. At least one participant, Della, a First

[6] Scoop survivors is the official term used for status Indian, Inuit or eligible to have status and who were removed as children from their families and communities by child welfare services over a 20-year period between 1960 and 1980, and placed in long-term care with non-Indigenous white families.

Nations woman, made the connections between childhood trauma associated with assimilation, her diagnosis of diabetes in pregnancy and her lack of breastfeeding success. As part of the 60's scoop, Della and her twin sister were separated from the rest of their families of origin at 17 months of age.[7] While Della remembered that they experienced generally good care with minimal episodes of racism in their white settler household, she and her sister experienced the loss of their culture and language and grew up to become what Della called "red apples"—red on the outside and white on the inside (field notes). When she was diagnosed with diabetes in her first pregnancy, she attributed it to chronic stress she experienced as a "red apple." Not surprising, she felt a great deal of uncertainty by becoming pregnant and being diagnosed with diabetes.

> The story about myself I guess from the beginning being out of an Aboriginal ancestry I am susceptible of course to being diabetic and it does run in our family and being on with first pregnant with my first son 15 years ago was when I was first diagnosed to be diabetic. I think it might have had an impact because I was dealing with not just only being pregnant but also being on newly diagnosis diabetes diabetic and I didn't know what to expect and being diabetic [ ] I was probably more in denial than anything because a lot of that happens to it people who are first found to be of the diabetic, is that they're in denial that they don't want to believe that they have this disease.

Della was aware of the prevalence of diabetes within First Nations communities.[8] In part, she accepted the view that First Nations people were more susceptible to diabetes and her own family's experience attests to the problem.[9] Della pointed out that her first response to the diagnosis was denial, which can be a short-term solution to providing some protective space to take in what is an overwhelming adjustment. Ironically, because some members of her family, as well as the high

[7] According to the American College of Physicians in a recent position statement on immigration, "separating a child from his or her parents triggers a level of stress consistent with trauma." This acute stress causes acute and long-term damage to the developing brain (van der Kolk). It can also be embodied as chronic stress and might become a precipitating factor in the onset of disease such as diabetes. (Kreger; McGibbon)

[8] In 2011, the rate of diabetes among Indigenous people was double the rate of 10.3% in urban First Nations individuals compared to 5% in the non-Aboriginal population. Diabetes is diagnosed at a younger age for Indigenous peoples, and the rate of gestational diabetes is higher in Indigenous women than in the non-Indigenous population. (Statistics Canada)

[9] The explanations for these disproportionate rates vary from the thrifty gene hypothesis to the poor socioeconomic conditions in which many Aboriginal people live. (Poudrier, 2007)

rates among First Nations people, she found some comfort in the fact that she was not alone in this diagnosis.

In a recent mothering talking circle with other First Nations and Métis women, Della, as a facilitator of the group mentioned that she also had been diagnosed with postnatal depression before she was discharged from her hospital delivery–a connection that she had not made at the time of the interview (field notes). Although the causes of this condition are multifactorial, the diagnosis of gestational diabetes along with the denial and with postnatal depression suggest that Della felt overwhelmed by feelings of disempowerment. This finding is consistent with the literature on women's experiences of gestational diabetes. For example, in a focus group study of eight women, the most common experiences were feelings of being disrespected as a non-compliant patient who could harm her baby by her self-indulgent actions (Nolan, 2011). As a result, these women were subjected to the medical gaze through additional monitoring, being exposed to patient education that was preachy, and using care tactics to increase compliance in birthing (Nolan, 2011).

From Della's experience, it is evident that diabetes is an additional stress and contributes to the unease already present as these women transition to motherhood. The diagnosis presents a double doorway to go through in orientating a woman's life to that of a mother with diabetes, who has both self-care responsibilities and the care of an infant. The passage through is made more troublesome when the medical providers use scare tactics with pregnant women who they felt were not comprehending the gravity of gestational diabetes on the health of their unborn infants (Nolan 614). Being diabetic requires for many people mastering a new self-care regime that involves lifestyle habits, food habits, and physical activity which in turn, necessitates resources–time, energy, emotional, physical and financial resources. Della did not elaborate on what resources this diagnosis demanded of her, yet she is the same participant who was forced to compromise her food intake so that her children could have milk in their diets. These choices suggest that her self-care was at times in conflict with her role as mother due to resource constraints.

Unlike Della, Kyla, another First Nations 60s scoop adoptee, recalled that her adopted parents disparaged her racial heritage, and she was forced to repeatedly express gratitude to them (field notes). Kyla, however, resisted this erasure of her First Nations identity and refused to submit to these stereotypes. She became a rebellious, strong-willed teenager in response to being sexually abused by her adopted father, and at the age of 14, she was put into foster care. These experiences

engendered a strong sense of self, independence, and resilience so that when it came time to give birth to her child, Kyla refused a hospital birth and was determined to give birth on her own if a midwife was not available (field notes). She was one of the women who benefitted from home birth services, but not until she pleaded with midwives to take her on (field notes). Also, she became the first First Nations client to have a home birth (field notes). As a teen, single mother recovering from sexual abuse, Kyla found solace in the woman-centered care she received in her home through the midwifery service. Her self-reliance enabled her to define the kind of home birth, a safe "woman-centered birth territory" that she wanted with the birth attendants of her choosing.

Although Kyla was able to retain the help of a midwife, some of the other participants had little or no support from anyone including their families. For the two women who were immigrants, their experiences during their pregnancies speak to disrupted family relationships brought on by immigration and displacement. English was not the first language of two Muslim women, making it difficult for them to communicate easily with health care providers. In addition, they were concerned, more than the other four women, about the lack of family support that might have mitigated this language barrier. Ferdousi, for example, did not have the emotional and financial support of her husband.

> Ferdousi: I was 20 when I got married, and 22 when I had my baby, so when I had the baby, he was almost 40 so almost 20 years older than me.
>
> Johanna: Was that an arranged marriage?
>
> Ferdousi: Yes. It was an arranged marriage… My husband was not that kind of partner [ ] not at all supporting me, so he did not support me.

Arranged marriages are not in themselves unsupportive; however, in this case, the couple immigrated shortly after the wedding, and Ferdousi became pregnant within a year of arriving in Winnipeg (field notes). Immigration meant moving away from family supports and financial stability. Consequently, the power relationship within the marriage shifted. Since Ferdousi was the main breadwinner in Canada, her pregnancy interfered with the family's economic prospects, leading to tensions between Ferdousi and her husband (field notes). This situation became more problematic when Ferdousi was diagnosed with breast cancer, and her husband began to

emotionally abuse her and then physically assaulted her. Ferdousi then realized that she was better off without her husband and became a single mother.

Political violence can contribute to disrupted family relations and contribute to domestic abuse. As the firstborn daughter in a family of seven children, Rahilah, who was born in Kabul, Afghanistan was expected to be responsible for household chores and for the care of her younger siblings. Rahilah first emigrated to India with her family to get away from the war that was happening in that city. Her father, a property owner and businessman stayed behind. It was in India that she married her husband. (She later immigrated to Canada and left behind her husband who was emotionally distant). Her first birth in India was in a public hospital where she says she was glad to have a Caesarian birth because the attending nurses in this hospital did not abuse her during her labour–a common experience of women who give birth in public rather than private hospitals in India (field notes). Yet she had a difficult time because she lacked familial support:

> I don't have a good experience from other people for myself. I cry a lot because my son Joseph, now he's 16. He was born in 2001 and when he born, I don't have any support. I have my whole family, my mother, my sister, my whole family around me, but nobody supports me, and I didn't have anyone, and I had a C-section and had to support myself.

Expecting assistance from her family, but not receiving any, caused her anguish. This situation appears to be out of alignment with Muslim family values. Rather than share the joy and happiness with the safe arrival of Rahilah's first-born child and her mother's first-born grandson, she was left uncared for. Lack of support at critical times can come from family relationships altered by other circumstances. The family's grief over an accidental death of Rahilha's younger brother, left in her care when she was a 14-year-old (field notes), may have been a factor in her family not providing the care she needed.

Family is an important source of support for many women during their pregnancy. It can help them to weather the uncertainty of pregnancy, birth, and motherhood while celebrating these changes. That was not the case for the two immigrant women who faced financial insecurity and many other pressures associated with integrating into a foreign country. Immigrant families, like Rahilah's, also come with issues related to displacement due to political disruption, violence, and

war. These additional pressures can have a major impact on spousal relationships, and during pregnancy, these tensions may be exacerbated, heightening these women's feelings of vulnerability and, in some cases, forcing them to rely on their own resources.

3.2.4. Intention to Sustain Breastfeeding. A mother's biomedical, social, and psychological history may have an impact on her birthing experience and her intention to develop her breastfeeding capability. According to Meedya et al., (2015) "women as embodied selves" is "an essential concept for breastfeeding success" that requires an "engaged combination of body, mind and spirit" (p. 265). This integration process can be achieved by supporting a mother to be an active participant in making choices around breastfeeding (Smyth, 2018). Women who intend to breastfeed benefit from the provision of care that is "person-centered" (Schmied et al.2012, p. 12; Meedya et al. 2015, p. 266) and "culturally specific" (MacVicar et al. 2015, p. 290). A mother who is empowered to integrate "practical skills and knowledge of breastfeeding" with confidence and self-efficacy (Dennis et al.2019 p. 11) can develop the capability to become a mother who sustains breastfeeding on her terms.

Ferdousi and Rahilah, both immigrants to Canada, came from cultures that provided the social capital to support maternal self-efficacy. In their cultures, they had grown up with breastfeeding as the "normal" way to feed an infant. Ferdousi spoke several times of the cultural context in she grew up: "I'm from Bangladesh and [ ] our culture back home, is everyone [ ] breastfeeding, I saw my mom and seven brothers and sisters, my mom breastfed all of us, and I saw everything." Moreover, this knowledge of breastfeeding led Ferdousi to conclude that breastfeeding was straightforward: "I doubt it's hard; it's really easy so I was wondering [ ] it's easy, not too difficult, [ ] if going to be mom then you need to breastfeed your kids so it's not too difficult." Similarly, Rahilah's exposure to breastfeeding led her to believe that it was the best way to feed an infant: "but it's it was my idea, breastmilk is the best for the baby and I start breastfeeding him since he was born, in oh, he was at two days when I start breastfeeding him." For these women, breastfeeding was the cultural norm; they had access to vicarious experiences in their homes that aligned themselves to cultural values for breastfeeding, which in turn, they relied on when they moved to Canada.

The desire to breastfeed can come from sources other than traditional values that include the aesthetics of breastfeeding, the longing for embodied connections to a child and breastfeeding

as a potential act of resistance and healing. Four of the six women lacked access to traditional cultural knowledge about breastfeeding. Della, as an adoptee who grew up in a white home and was disconnected from her Cree culture, had only seen one other woman breastfeed in her life–the daughter of her adopted mother who was a professional nurse and who felt free to nurse her child in a shopping mall: "I remember her breastfeeding in the mall just doing it, you know, I think it was more common back then, but I don't know." "Just doing it"–breastfeeding in a public space–caught Della's attention as a child and later encouraged Della to try breastfeeding in hospital with the help of an experienced nurse that she trusted. In a more recent experience of seeing a woman breastfeed her child in public, Della was enthralled by the mother's unflappability:

> Just the other day I seen a mother, a young Aboriginal mom, and her baby was crying at the Food Bank Clothing Depot and she didn't skip a beat. Her baby is crying; she just she just took her baby out of the stroller and just nuzzled her up to her breasts and put a blanket over and just continued on. So that was kind of cool.

As Della's experiences of breastfeeding were cut short by her diagnosis of diabetes and postpartum depression, her attention to this scene, and the words she uses "just nuzzled her up to her breasts" suggests a yearning for a missed opportunity in her life.

Breastfeeding for some Indigenous women was too closely aligned with traditional, Indigenous ways that denigrated them "primitive." Many First Nations and Métis women recall their mothers being discouraged from breastfeeding (Anderson, 2011). Yet, Jasmyn, a Métis woman, who grew up in a family where her mother bottle-fed, saw breastfeeding as a way to challenge her mother's indifference to breastfeeding:

> I think in a weird way [ ] breastfeeding became kind of [ ] a rebellion to my mother, I remember being pregnant with Teagan and she was [ ], "oh well, if you can't breastfeed that is not a big deal." I was [ ] five months pregnant, like "no, Mom I'm going to try." I don't know why I felt the need to rebel. It was never like she was [ ] a terrible mother; she did the best she could, but I just wanted [ ] to prove something.

In Jasmyn's mother's view, breastfeeding was a "difficulty," and bottle-feeding was seen as "convenient." As previously discussed in the literature review, these beliefs are consistent with the views of breastfeeding in white, middle-class western cultures and the loss of breastfeeding knowledge in low, socioeconomic status communities (MacVicar et al., 2015). These ideas perhaps indicate the extent of the medicalization of breastfeeding over the latter half of the twentieth century.

Even if mothers have not breastfed their children, other family members or close friends who have breastfed, can become role models for women who have had no prior exposure to breastfeeding. Jasmyn, for example, without the example and support of Sarah, a slightly older woman, who was also her sister-in-law and doula, would probably not have breastfed her child: "Breastfeeding was being like[] an interesting thing like[] and it's just like[] I can't see myself not breastfeeding but I also think that like []if Sarah had not been around me I don't know if I would have breastfed because like []she was there while she was my doula also but sister-in-law bonus." This relationship, and the ease with which Sarah breastfed her children, was sufficient for Jasmyn to initiate breastfeeding and to overcome the challenges that she encountered.

For women who have experienced sexual abuse, the idea of breastfeeding can be an emotionally challenging one. Wood and Van Esterik's (2010) study of six survivors of childhood sexual abuse and breastfeeding in Saskatoon uncovered both the potential for re-traumatization through insensitive medical care and also the potential for transformation based on the women's experiences of the functional capacity of the body through breastfeeding. Two women in this study, who had experienced sexual abuse, saw breastfeeding as potential for healing themselves before they had actually experienced breastfeeding. Kyla was inspired by seeing another woman successfully breastfeed her children, which provided an image of motherhood that signaled a harmonious relationship between material (the body and nature) and immaterial experiences.

> I always knew that I was going to breastfeed my baby when I first found out I was pregnant. I was like []there is no doubt in my mind that I was going to breastfeed because historically I had never really known a breastfeeding mother until this one lady that used to go to my church was breastfeeding and I thought it was cool that she had so many kids and I thought that was really neat and interesting how she was breastfeeding and none of the other mothers were breastfeeding and I thought

> it was a really like [ ]spiritual and [ ] sort of natural and [ ] it's sort of like an image of womanhood and motherhood something that I wanted I feel like []that was what my vision of being a mother was, was being very in tune with nature with my body and with myself, and [ ]that's what I wanted for myself.

As a rebellious adoptee, struggling with the impact of domestic sexual abuse, Kyla strived to be seen as an authentic and capable mother. She saw herself as a survivor of both incompetent mothering from a birth mother dealing with addictions, and from an adopted mother who was infertile (field notes). Breastfeeding was a marker of competence for her; she perceived herself as the "real" mother of this child, and that she was capable of caring for this child.

The physical connections between mother and child and between spirituality and nature speaks to the reciprocity of the maternal dyad as a "natural," biological unit that is part of the First Nations culture. Kyla, however, was not familiar with her cultural teachings (field notes). Nonetheless, seeing a white mother breastfeeding in a Christian church affirmed for Kyla that breastfeeding and motherhood had a spiritual basis. "Motherhood has rhetorical force" (O'Brien Hallstein, 2006, p.1); it is "a god term" in culture, "shaping positive connotations, assumptions and ideals about women, family and society" (Buchanan, 2013, p. 8). Buchanan also locates motherhood in art as an "available means of persuasion" (p. 3). The imagery of the Virgin Mary with the child Jesus, for example, is often painted in a breastfeeding position—an image that would seem to have allowed Kyla to imagine the beauty in her relationship with her body and her child. This vision has perhaps brought an aesthetic back to her life, one that was forgotten due to her experiences of racism, adoption and sexual abuse.

Women who experience sexual abuse as children have memories of being left at the mercy of the perpetrators; they could not control who had access to their bodies. As adults, they have to deal with effects of the traumatic disruptions to their body boundaries. Wood and Van Esterik (2010) have found that breastfeeding can be a way to recover from sexual abuse by women reclaiming their bodies. For Sarah, whose First Nations' father was a residential school survivor and had sexually abused her, breastfeeding gave her a sense of control over her body while allowing her to enjoy the experience.

> I want to breastfeed and I had went into breastfeeding not necessarily just for my baby; it was a thing for me because being a sexual abuse survivor, I felt [ ]I was taking my body back; that I was doing what my body was meant for what made my body feels good and it's supposed to be really positive thing.

This trust in her body's capacity to lactate was the way in which she could engage with motherhood in an empowered way. Reclaiming her body enabled Sarah to make bodily choices, act autonomously, and find bodily integrity that she had lost when she was sexual abused. Like Jasmyn and Kyla, Sarah desired to develop the capability to breastfeed as a way to resist the oppression experienced within her family.

3.2.5. Support of Caregivers. The creation of a woman-centered space depends on the development of a collaborative and trusting relationship between the mother and her maternity care providers who facilitate women in their choices (Flacking, 2006; Kronberg et al., 2015). Of the six women, three were supported by a woman-centered approach to birthing and breastfeeding in their first births. Kyla was the most successful in creating these conditions in her own home with midwives assisting in both of her births. She had immediate contact with her baby after the delivery; her babies latched well, and she found breastfeeding easy to initiate. Della also felt supported in her first birth in hospital:

> I had a very experienced nurse; she was an older lady so she knew the hospital, you know what she was very helpful towards me when I was trying to breastfeed my son in the hospital. She was just an amazing woman; [ ] you just could tell she had experience and she was here right in there and telling me you know you go to know make, make sure the baby latches on and everything [ ] that is very, very helpful.

Although Della received excellent encouragement for breastfeeding and trusted the older nurse who "knew the hospital;" i.e. "the system," a place that was unfamiliar to Della, this women-centered care did not extend beyond the support she received after the initiation of breastfeeding. A few days after the birth, but before she was discharged from the hospital, Della was diagnosed with post-partum depression; with this diagnosis she stopped breastfeeding.

Despite midwifery care positioning itself as women-centered care, not all women who have midwives experienced care in this way. For example, Jasmyn, who had a midwife at both of her births, felt pressured by her midwife to deliver in hospital. This midwife became concerned when Jasmyn's water broke and they contained a small amount of meconium while a second midwife did not believe that the meconium staining[10] indicated an emergency.

> …there was another midwife, she said I think it's ok. It is just a little bit, but [the midwife in charge] panicked so that meant going to the hospital. I was only there five minutes before she was born; because she panicked, she called NICU. We went to the NICU and then you know I gave birth and they immediately took her away from me, even though [ ] she was crying she was breathing; she had color she was fine, but they [ ] they took her away from me.

In Jasmyn's view, the move to the hospital shifted the experience of the birth process from a woman-centered to medically-centered care. She felt a loss of control when the hospital took her baby away from her, a phrase that she repeated twice in the same sentence. In this case, the medical care protocols for safe midwifery care and the midwife's focus on the survival of the infant diverted their attention away from the mother's needs for empathetic care. In addition, the decision to place the baby in NCIU was at odds with Jasmyn's perception that her baby was doing fine after birth and did not need additional measures. This turn of events left Jasmyn feeling upset and disempowered.

> We went home nursing, which I kind of remember being filled with [ ] this overwhelming sense of [ ] doom and[ ] I have to take care of this, I don't want to cry. I went home and then [ ] things were probably normal but it just seems so much worse, I didn't realize until I got a month along that this was at postpartum depression.

The unexpected turn from woman-centered care to a medical emergency may have contributed to the postpartum depression Jasmyn dealt with after her first birth.

[10] Meconium is the dark green fecal matter produced in an infant's gut during pregnancy. Fecal staining of the amniotic fluid stool is a red flag that the infant is under potential stress during the delivery.

Lack of woman-centered support during the prenatal period may also lead to difficulties during the birth process and in initiating breastfeeding. As discussed earlier, Sarah believed that the stigma of "teen mother" overshadowed her prenatal and birthing experience. Even though she found a Frist Nations female doctor whom she believed would share the same values as her, Sarah felt the doctor treated her "like a little kid" in instructing her how to deliver her baby rather than letting her experience the labour fully. The spiral of birth interventions led to her traumatic birth and difficulties in initiating breastfeeding.

> My first experience of breastfeeding was pretty awful and there's a lot of things that contributed to that. My prenatal experience wasn't good and then I had a very traumatic birth, my baby had a traumatic birth, he struggled. Baby was very colicky immediately after birth and breastfeeding was difficult. Some of the nurses said they thought there was something wrong with my milk. Instead of trying to find what was really going on with my baby, the doctors just said he must be allergic to your milk and so they told me that I should put him on this formula.

In the process of learning how to breastfeed their newborns, women may feel they are on a "shaky ground" and "searching for a foothold" (Kronberg et al., 2015, p. 82). For Sarah, that shaky ground experience was aggravated by how she was treated. Pushed into a role of being a child rather than a woman with agency, Sarah found that her desire to breastfeed was ignored by her physician and the nurses responsible for her care. Sarah's interactions with nurses and the doctor reinforced the message that her baby's struggles were related to the quality of her milk, and that her body was "deficient." The nurses, she felt, were rude to her. For example, a nurse who was helping her to latch the baby "grabbed" at Sarah's breast and put it into the baby's mouth. When Sarah asked her to stop, the nurse did not seem to hear and grabbed her breast a second time. In this situation, the nurse violated Sarah's bodily boundaries initially by "grabbing her breast" and then by ignoring Sarah's request to stop. In the process, the nurse also denied Sarah's agency; instead of allowing Sarah to breastfeed in her own time, the nurse took over. This example illustrates the ways in which "expert" medical/nursing knowledge can colonize women's bodies. Regulating a mother's experiences rather than listening to her is one of the "damaging values" that Ekstrom et al., have identified in professional postnatal care.

Despite a lack of empathic support, Sarah persevered in her attempt to breastfeed and was affirmed for her efforts by another nurse, whom Sarah now knows as a lactation consultant.

> I was side lying, nursing my baby because it was the only way we were comfortable. A nurse had yelled at me for nursing him that way. Moments later a nurse, not mine, entered the room and said, "wow! Look at you! Is this your first baby?" I replied with 'yes,' and she said, "you wouldn't guess it; you look like an old pro!" It was exactly the encouragement I needed.

The phase "you look like an old pro" provided an image of herself a as capable mother, a powerful metaphor and antidote to the negative messages of deficiency that Sarah received from the other nurse. This praise gave Sarah a foothold on which to develop her capability to breastfeed in the face of conflicting advice. In retelling this birth story on another occasion, she said "I held on to that [image] for a long time" (Field notes). Self-confidence is a critical factor for women in the development of self-efficacy (Dennis et al., 2019, p. 11). Sarah's journey was difficult in developing her capability to breastfeed, but she demonstrated agency as she refused to accept the stereotypes of a First Nations teen mother, which undermined her sense of self, and motivated her to seek out culturally specific care. Her narrative demonstrates the importance of the affective care that women need to retain their self-confidence as they transition from pregnant women to breastfeeding mothers.

The transition to becoming a mother while also transitioning as an immigrant into a foreign culture can be very challenging. Language is an aspect of culturally specific care that can mediate this transition. In a research done with immigrant Muslim women in Canada, Reitmanova and Gustafson, (2008) and Benza and Liamputtong (2014) and found that weaker language skills were the number one barrier in the maternity care requirements for these women. Language barriers also have been found to be a risk factor for adverse outcomes and increased medicalization of care (Timmins, 2002). Rahilah and Ferdousi, both Muslim women, who had been living in Canada for 10 or more years at the time of the interviews, talked about their lack of confidence in conversational English and in reading the language (field notes). Rahilah who would express distress and ask for help to find the English word she needed to express herself (field notes). Ferdousi arrived in Saskatoon in 2009 and had her first baby within two years of emigrating from

Bangladesh. As a factory worker, she had no access to language classes (field notes). She expressed her distress to her partner who, despite knowing English better, refused to help and left her on her own in the hospital.

After the birth of her son, Ferdousi stated that she had no assistance in initiating breastfeeding: "when he was born, no one was here to show me or tell me about breastfeeding." Ferdousi realized that it wasn't as easy as it looked, and that she lacked the knowledge to breastfeed: "And when he was born then after a little while they give me my son, and I was wondering [ ] I thought [ ] I can but I was trying to feed him but I can't [ ] he can't properly nurse because I don't know, I thought at first it is easy but it wasn't easy; then nurse came and they helped me for three to four days they are helping me." The reference to the assistance of the nurses is at odds with Ferdousi's first statement that "no one was here to show or tell me about breastfeeding." Thus, Ferdousi was not alone in the physical sense, but she needed someone who could understand her within her own cultural context.

Unfortunately, just as Ferdousi's milk came in on day four, and perhaps as result of her difficulties in initiating breastfeeding with him, her son contracted jaundice[11]. At the physician's direction, she was advised to discontinue breastfeeding for a week even though Ferdousi was able to pump her milk[12]: Not surprisingly, this course of action led to a new set of problems as she had to endure her infant's crying as she weaned him from bottle-feeding back to breastfeeding.

> My family doctor, she said you have to feed him because he was [breast]feeding before you was bottle-feeding before him; but right now, he used to bottle-feeding so you have to work hard for that, [and] then he will and then I was trying to work hard [ ] I know he was crying; he doesn't like to come to my breast. And then I was really tried and tried, [ ] he was crying and I never gave him the bottle of milk and then I said all I have to, and then within one week, he again come to my breast.

[11] Newborn jaundice is a red flag that an infant is not receiving sufficient breastmilk and is having difficulties with latch and transfer of breastmilk. Jaundice in newborns is a normal aspect of the infant's physiological adaptive process. Newborn jaundice can occur in the first week of life, peaking between three and five days and resolving with the elimination of the infants' meconium or black stool by the end of the week. (Lauer and Spector)..

[12] This course of action is out of alignment with treatment protocols for neonatal jaundice in breastfeeding infants. Lauer and Spector recommend supporting breastfeeding rather than disrupting it to overcome this problem.

Whereas most women are discharged within 24 hours after delivery, Ferdousi's stay in hospital was extended for a week; she received additional nursing care to help her establish breastfeeding in hospital, but she left the hospital pumping milk and bottle-feeding. She needed another week of hard work following her discharge from hospital to support her baby to breastfeed. Ferdousi continued to receive weekly public health nurse visits that she found very helpful because she learned some skills to breastfeed successfully: "You need to learn something [ ]there's some techniques, the nurse she show me that and I follow that and after she stopped coming my house because it was an one month done and then it's been going [ ] that I was feeding him."

Initially, Ferdousi was on "shaky ground" when she began her birth and breastfeeding journey. Ferdousi faced many challenges—birthing in a new country, away from family, lacking spousal supports, and coping with a language barrier. Throughout this process, Ferdousi was "searching for a foothold" (Kronberg et al. 84), which seems to have been driven by her determination to breastfeed and by developing the necessary skills to breastfeed successfully. Nowhere in her narrative does she talk about losing trust in her health care providers, of being frustrated with the slow progress, or in giving up on her desire to breastfeed. Gradually, and with support of a public health nurse who mentored her, Ferdousi became "at ease" with breastfeeding.

Together, pregnancy, birthing, and the immediate postnatal period are life-altering. Women often tend to feel ambivalence and loss of control during these stages. The six participants of this study were able to identify and face the challenges that came from intersecting forms of oppression. As (single) First Nations and Métis women and immigrant women of colour, the transition to motherhood for these women was challenging. Yet, their responses to these challenges were markers of their intuitive understanding of their need for emotional safety and their agency in addressing this critical vulnerability. Developing their capacity to breastfeed meant dealing with barriers to accessing home birthing, negotiating consent issues and dealing with medical care practices that were disruptive to their intention to breastfeed.

Chapter 4

Maternal Capability

In this chapter I continue the narrative analysis of the experiences that the participants describe as they integrated sustained breastfeeding practices into their daily lives. These experiences reveal how women developed their capability to become breastfeeding mothers who maintained their breastfeeding relationships as an aspect of their intentions. This transition from initiating breastfeeding to integrating breastfeeding in to their lives involved trusting their own bodies, developing their maternal authority, resisting disintegrative internal pressures, resisting the pressures to bottle feeding. Negotiating public spaces with breastfeeding child can become a barrier to breastfeeding from mothers particularly immigrant mothers who are uncertain about cultural norms. The SMC has a role to play in supporting this transition to sustained breastfeeding.

4.1. Incorporating Sustained Breastfeeding into Daily Life

Sustained breastfeeding is an outcome of responsive intimate contact and support to create a woman-centered space; that is, a "breastfeeding territory" where a mother can breastfeed whenever and wherever (Meedya et al. 2015, p. 269). "Finding a foothold" helps mothers to overcome the uncertainty of the betwixt and between stage of breastfeeding as they establish this nurturing relationship with their baby (Kronberg et al., 2015, p. 84). The time to develop this capability is defined as the "breastfeeding bonding trajectory" that extends beyond postnatal recovery into the first year (Kronberg et al.2015, p. 84-6). During this period, a first-time mother moves from using external cues for performing breastfeeding to an embodied experience that she interprets and modifies for herself within the constraints of her particular circumstances. This breastfeeding bonding trajectory is a transitional phase of physical and mental changes. It is an opportunity to forge a new identity along with positive community recognition for assuming the associated responsibilities of this new status (van Gennep, 1960).

For women who are breastfeeding as part of their mothering practices, incorporating breastfeeding into daily life can bring challenges and expose vulnerabilities at the personal, family and community level (Carter, 1995; Smyth, 2018). Five of the six women in this research project transitioned from initiating breastfeeding to developing the capability to sustain breastfeeding by incorporating it into their everyday experiences. Each of them demonstrated a trust in their bodies to rely on a "breastfeeding territory" to make it happen.

4.2. Trust in The Maternal Body to Sustain Breastfeeding

Breastfeeding practice is built on different forms of intimate relationship in which a woman shares her body with her child in a new way. This sharing requires an intuitive trust and value in the maternal body as a parenting resource and the ability to deal with challenges (Dennis et al., 2019). Successful breastfeeding comes from the connection to personal "integrative power" in which the body, mind and spirit are in harmony so that women "respond spontaneously and expressively to bodily sensations and intuition" that support the development of the capability. Challenges are opportunities for women to tap into integrative power as they discover "deep, hidden capability within their embodied selves" (Meedya et al.; 2015, p. 390). Women are vulnerable during this time to moral judgments about infant care and they may become "alienated" from this breastfeeding role (Smyth, 2018, p. 2). "Disintegrative powers" may also present, from within herself or others, and can interfere and suppress the capability to breastfeed successfully (Meedya et al.; 2015, p. 268-9). Rahilah's intention to breastfeed was rooted in her trust in her own body, and her capacity for integrative power:

> I had a C-section and [had to support myself] because I don't know I wasn't educated like you guys. You know about the breastfeeding but it's it was my idea breastfeeding; breast milk is the best for the baby and I start breastfeeding him when he was since he was born in hospital. He was at two days when I start breastfeeding him and it was so hard to breastfeed the child and my body is changing and I didn't have anyone to help me you know, to come and give me some advice as the oldest, like a mother, or mother-in-law, or sister, or neighbor or something. I didn't have any help when I was alone with my child and my husband was working. So I was becoming my own doctor. You know I have myself and I was decide. I have to breastfeed him because breastfeeding, breastfeeding with him it's I find lots of benefits on my son when I breastfed him.

Although Rahilah was not formally educated about breastfeeding, nor did she have any familial support, she relied on her intuition: "it was my idea, breastfeeding," and that "breastmilk is the best." Rahilah took control of the situation: "I was becoming my own doctor. You know I

have myself and I was decide." She relies on herself to engage in building this breastfeeding relationship from which she clearly sees benefits for her son.

Many first-time mothers find breastfeeding challenging since they do not yet know how to interpret their babies' behavior. This was the case for Jasmyn: "I remember just feeling [ ] I wanted to breastfeed but same time [ ] why is it baby keep waking up, clearly [ ] I'm doing something wrong. Anyways, [ ]Sarah was always around and then [ ] I just stuck through it." Having Sarah's help was an important factor in encouraging Jasmyn to persist, and provided her a positive, woman-centered space. Thus, Jasmyn began to trust breastfeeding as a bodily experience, and it became an aid to recovery from her postnatal depression. She first realized her accomplishments when she went to the first postnatal depression support group meeting when her baby was three months old.

> If I sat down and thought about it maybe…[ ] didn't think about it being something… I don't think I am aware of, but it is something I am vocal about, nursing through postpartum [depression] and stuff… actually I was the only woman in the postpartum group, at West Winds that was still nursing. The only woman there that was still breastfeeding, as ever one else had switched to bottles. they were [ ] "it is easier, as you know you can give the baby to the partner" but I think they mentioned once or twice there that nursing helps the bond and stuff. As a breastfeeding mother and is a kind of being [ ] one of the most [ ] meaningful things I've done because [ ] I can look back to you know, when I went out and hung out with my friends and partied, [ ] nothing came from it was just [ ] money gone and then you know whatever work to make more money in repeat. But breastfeeding this is only thing that seems to [ ] means something and then something that I can see the results of it's not just see you throwing money away for a good a good time with friends.

Jasmyn was surprised to learn that she was the only woman still breastfeeding in the postpartum group. Even though these mothers seemed to be aware "that nursing helps the bond and stuff," they may have lacked support, were unsuccessful at initiating breastfeeding, and now preferred the ease of bottle-feeding. Jasmyn found breastfeeding a

profound, life changing experience, "one of the most [ ] meaningful things [she had] done." Although she was free from responsibilities in her single life, partied and spent money and then worked to do it all over again, these experiences, in retrospect, seemed frivolous and wasteful. She now took pride and pleasure in the results—a healthy and thriving child. Through these reflections on her stories, Jasmyn persisted in her intention to breastfeed knowing its value to her and her baby.

Kyla had a paradoxical experience of breastfeeding. On the one hand, she discovered that she truly enjoyed breastfeeding as a bodily and spiritual experience when her child was born; on the other, she experienced milk ejection dysphoria[13] when she nursed her second child.

> I didn't know I would enjoy it as much as I did , I did I really enjoyed the process of breastfeeding I really felt like [ ]I was providing for my baby, I was like my body was doing what it was supposed to do it felt very complete and very like natural even though I did suffer from that feeling when I was breastfeeding what was it called again like breastfeeding aversion. I suffered quite a bit from that but I also think it had something to do with just like I'm emerging from [ ] being in a physically abusive relationship. And like I said it was like the discovery of [ ] my sexual abuse as a child and [ ] I think that there was a lot of circumstances that [ ] led to my breastfeeding aversion. But I really enjoyed it and I really pushed myself to do it and even though I did feel that way about it when I get the letdown but I was determined to continue to breastfeeding, and [ ]by the end it [ ] didn't bother me at all.

The physical pleasure of breastfeeding as a holistic bodily function provided Kyla with a sense of satisfaction and purpose because she "was providing" for her baby: "My body was doing what it was supposed to do; it felt very complete." Through breastfeeding, Kyla gained confidence and a sense of self-sufficiency, something she craved as a way to distance herself from her adopted

[13] Dysphoria is a medical term, meaning an unpleasant or uncomfortable mood such as sadness, restlessness, anxiety, or irritability. Etymologically, it is the opposite of euphoria. As this condition is directly related to the milk ejection reflex or let-down, we chose the term dysphoric milk ejection reflex (D-MER). D-MER can be a part of every MER to some degree, usually less intense as the feeding goes on, although not always. www.llli.org/what-is-d-mer/

family (field notes). Breastfeeding her second child was more complicated, however, since her bodily memories of being sexually, physically, and emotionally abused, first by her adoptive father and later by the father of her child, became entangled with the physical experience of breastfeeding. Although she recognized this "disintegration power" (Meedya et al.; 2015, p.268-9), she persisted in breastfeeding, relying on her pleasurable memories to resist the negative effect of the dysphoria.

4.3. Resisting Pressures to Bottlefeed

Most of the participants dealt with the challenges of breastfeeding in a subtle and less confrontational manner. In Kyla's case, however, she proved adept in her self-conscious navigation of the dominant discourses of "intensive mothering" and "breast is best." To her, breastfeeding is an exemplary mothering practice that allows her to be a good mother while resisting racist practices and white norms:

> …one of the reasons why I breastfed is because the social norm is to bottle-feed and I didn't want to do that because mostly because it was the norm. My self-identity, e[ ] was really tried to like being a good mother, [ ] that meant so much to me because I'm adopted and I don't really have a lot of [ ] family and I guess [ ] part of it is that [ ] you know that pressure to be [ ] you know the best mom because you're First Nations person and you [ ] have to like you give a good positive image of [ ] yourself as a mother all that jazz, and so [ ]I guess [ ] I have internalized a bit, [ ] as much as [ ] I am opposed to ass-kissing to white people to [ ] prove myself for them [ ] I think part of it is kind of like yeah I like try to protect myself with that overly [ ] concentration on my parenting skills.

As someone who was part of the 60s scoop and adopted, Kyla experienced the disruption of familial ties based on kinship and culture. Breastfeeding allowed her to recreate a positive experience of family with her infant. Aware of the dominant construction of teenage, First Nations mothers as "bad" mothers, Kyla felt "the pressure… [to be] the best mom because you're First Nations person." Being a breastfeeding mother offers a counter image to these stereotypes, which is part of a more general practice of resisting white dominance and conforming to white

expectations—"[she] is opposed to ass-kissing white people" to prove herself. Nonetheless, continually dealing with discrimination took a toll on Kyla. Breastfeeding and devoting herself to her parenting skills were ways of insulating her from these ongoing sources of pain.

The pressure to bottle-feed in public often interferes with women's ability to embrace their identities as breastfeeding mothers. This issue is particularly true for low-income women who lack the symbolic capital that comes associated with extended education and higher incomes. In the absence of this power, many young women may reject breastfeeding (Groleau et al. 2013). Sarah, as a teen Frist Nations mother who was still going to school, felt a lot of pressure to bottle-feed from her doctor and the office staff.

> … well I started noticing that there was a lot of formula advertising in the clinic, they're very quick to give away free samples and I realize it was most likely just the easiest solution. And I think, she [the doctor] thought because I was young and going to school and that, but that's what I would want, that it would be easier for me because I was in school.

Since the clinic is a key medical worksite, it both attests to and constitutes medical authority; this space then confers legitimacy on formula-feeding as a positive option and easily accessible through the dispensing of free samples. Moreover, recognizing that Sarah was young and still attending school, the office nurse encouraged Sarah to formula-feed her baby since the nurse believed that Sarah would be less tied to her baby. Bottle-feeding seemed to be an easier way to balance Sarah's educational goals with her baby's needs. The pressure to breastfeed was exacerbated by her physician's diagnosis that her baby had developed an allergy to breast milk, and he recommended that Sarah bottle-feed her baby. Initially, she complied with his suggestion, but her baby did not like the formula milk:

> Doctor said I should put him on this formula which since has been recalled and is not used anymore, some expanding formula[14], so we put them on this and I knew that he wasn't better, just throwing up less but he was still always upset and always crying so I became a closet nurser, only nurse at home when nobody was around and I didn't tell people I still breastfeeding but I breastfed until he was 14 months, but it was it was a weird thing because he would want to nurse when we were out and I have a bottle for him because I didn't want people to know that I was nursing him to do supposed to be allergic to my breast milk and it was just quite a bizarre and kind of traumatic thing.

Sarah, a teen mother who would have been seen by the health care system as "uneducated," resisted the doctor's advice. She relied on her experiential knowledge, based on her observations that her child continued to be "always upset and always crying." In defying medical authority, which may have had negative consequences, Sarah became "a closet nurser;" she created a breastfeeding territory in her bed where she felt safe to breastfeed. According to Sarah, "he nursed most effectively late at night time and I needed to sleep all night long so I would latch him on and let him nurse all night long." This symbiotic arrangement allowed both the mother's and the child's needs to be met. When in public spaces, however, Sarah felt forced to compromise her baby's desire to breastfeed and bottle-fed him instead.

Sarah's success in breastfeeding was facilitated by the support she found in a childcare worker at the alternative high school she attended. This older woman provided a counternarrative to the medical advice, making Sarah aware of "differences between breastfed babies and non-breastfed babies." These were differences she did not elaborate on, but this conversation helped build Sarah's confidence in her decision to breastfeed. Sarah trusted the childcare worker who was "one of the few people who knew I was still breastfeeding him," and she created a woman-centered space by helping with her baby and encouraging her to nurse at the childcare centre. Through this childcare worker's support, Sarah became confident in her breastfeeding ability and leveraged it by experimenting with various ways to be a breastfeeding mother with her next three children.

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[14] Formula that thickens in an infant's stomach is intended for infants with mild GER and should be used only when recommended by a physician. Thickened infant formula does not decrease frequency of reflux episodes but may decrease visible regurgitation, which may improve quality of life for caregivers. (Alberta Health Services, 2018)

> I was determined for it to be nothing but a powerful and empowering experience so I became a very feminist activist type breastfeeder, kind of fun in your face boss, when I came to breastfeed and then third son came along I was able to just breastfeed him and there wasn't any of the other stuff there wasn't the politics of breastfeeding so it was a really, really positive experience by the time I came around and so I breastfeed him till he was almost four years old.

By her second child, Sarah had embraced breastfeeding in public as a political statement, adopting identity as "a very feminist activist type breastfeeder." In taking this self-conscious stance, Sarah was well aware that breastfeeding is a public performance that positions the breast as defiantly confrontational ("a kind of fun in your face boss"), disrupting patriarchal representations of the (sexualized) breast. By the time her third child was born, however, Sarah no longer felt the need to interpret breastfeeding as politic act; rather breastfeeding had become a state of being—"a really, really positive experience." She was able to create a breastfeeding space where she was at ease and could sustain her breastfeeding relationship until her baby was a toddler.

The birth of her fourth child shook Sarah's confidence in her breastfeeding skills as she was unable to successfully latch. It took two painful weeks for the baby's tongue tie to be diagnosed and repaired before she was able to resume breastfeeding. However, by pumping her milk over the two-week period, she was not only able to provide her child with milk, but she shared "surplus of milk" with a baby whose mom had cystic fibrosis: "My milk was the only thing baby could hold on cuz he had severe tummy issues." Sarah's ability to share her milk was "like a big, kind of big hurrah." She had refuted the medical diagnosis that her milk was a problem for her first child, becoming a radical breastfeeder for her second, while providing milk for her fourth baby, as well as another with digestive problems.

4.4. Negotiating Public and Private Spaces

Since the early decades of the twentieth century, breastfeeding in public has been considered a taboo, especially for North American, white, middle-class women, and bottle-feeding has been promoted as the convenient alternative. Of the six participants in this project, Kyla resisted the taboo of breastfeeding in public most directly:

> I see myself as a breastfeeding mother. I've always been a very liberal person. I've never felt embarrassed in front of other people [ ] and if I do feel embarrassed it's to make everyone else feel comfortable to say [ ] I should feel embarrassed by the situation ,I really don't, but I if I act like I do it's because I want people to feel comfortable around me and not like I'm just weird person that doesn't care about other people.

Because Kyla was seemingly unconstrained by patriarchal norms of women's bodies "she has always been a very liberal person," she had a positive body image. She defined herself unequivocally as a breastfeeding mother and she sees herself as a "good" mother. That means she breastfeeds in public spaces and does not feel embarrassed; however, doing so would likely result in her being judged as a "bad mother." Therefore, she feints embarrassment for the sake of social convenience, making people feel less uncomfortable, but she acknowledges this ruse gets around patriarchal views of motherhood.

Breastfeeding in public spaces may be more of a challenge to women who immigrate to Canada as they are less sure of how to bend the social rules without offending others. Confusion and conflict with beliefs are a common theme in research on lived experiences of immigrant women (Benza and Liamputtong , 2014). When these women deviate from the cultural norms of their adopted country, they may risk integrating into their new community. In Rahilah's home country, Afghanistan, breastfeeding in public is culturally accepted provided that the Muslim woman remains completely covered as she nurses her child. In addition, infants are typically breastfed for the first year to 18 month, but male babies are breastfed longer than female infants (Field notes). When she moved to Canada, Rahilah was pressured by her maternal relatives to stop breastfeeding because it was unusual for older children older than two years of age to continue to be breastfed.

> … even my grandmother, she was in Afghanistan now she's passed away, so she phoned me she told me "shame on you, stop breastfeeding Joseph because you already pregnant with another child and he's a big boy. In my culture and my holy religion, Islamic religion, we have to breastfeed the child for a 2½ years. But when

> Joseph was not a year old, my mom in Saskatoon she attacked me and my grandmother from Kabul, Afghanistan they start attacking on me, telling me, no, you have to stop. Shame on you; this is not good, he's a big boy. He needs to eat food don't breastfeed him. I told him okay yes but I never stopped breastfeeding him.

Although unspoken, it would seem that her relatives feared that she might be perceived as a "backward" and/or "traditional," immigrant woman who engages in "gross" practices. Their injunctions, however, put Rahilah at odds with her own cultural and religious beliefs. Forced to choose between two competing options, Rahilah adopted a ploy of seeming to acquiesce to maternal authority by agreeing to stop breastfeeding, when, in fact, she continued.

Language barriers and a "lack of continuity in postpartum care" (Benza and Liamputtong 2014, p. 576) have implications for learning how to breastfeed in public spaces. For many immigrant women, breastfeeding can be a lonely journey if they have no connections with women in their own culture in Canada. Ferdousi managed to breastfeed her baby in the privacy of her home for eight months without connecting with other mothers about breastfeeding. She explains, "I don't know, really, I could ask someone, did I ask someone but I did not ask anyone, I don't know who I am. yeah, I cannot ask." No one appeared to have reached out to Ferdousi, nor did she have anyone to talk to: "No one tell me, and I did not have any experience." The lack of cultural support also had a negative effect on her identity as reflected in her statement, "I don't know who I am." Regardless of being isolated, Ferdousi breastfed her child successfully, but when she introduced solid foods after six months, she may have gained some more mobility.

> And then six months later, I started to him to give them solid food. And then when I start the solid food I did not notice that [ ] what he need[s]. I need to give him some, not large amount of solid food, [ ] that where he can going to be feel hungry and he can come to my breast. And I cannot [breast]feeding him; but I did not notice that I just gave him [ ] morning, afternoon and evening all the time cereal, and fruits vegetables all those like a solid food. And then, that way he is going to be full all of the time so when I try to nursing him, he doesn't like. Because he won't because he's full so I did not notice that he I'm giving him the solid food so he's not going

to be come to my breast and then I can feed and then he doesn't like and then after eight months he just to stop to feed.

Ferdousi needed to balance her priorities with her cultural expectations that she was a breastfeeding mother. When the baby rejected her breast in preference for solid foods, the weaning process became irreversible for her. Here, the baby's response becomes a way to end the relationship that has been restricting her to her home where she has lost her sense of her identity.

4.5. Sustained Breastfeeding and Need For Affiliation: the Role of the SMC

Affiliation with others who are experiencing similar changes is an aspect of coping with vulnerability of biosocial change (Turner, 1969, p. 360). A sense of affiliation allows individuals to share the joys as well as the challenges of coping with stressful changes (Taylor 85). Feelings of safety are dependent upon a sense of connection or affiliation with others who share a similar experience (O'Reilly, 2013, p. 185). Nussbaum (1995) defines affiliation as "being able to live with and towards others, to recognize and show concern for other human beings, engage in various forms of social interactions; to be able to imagine the situation of another" (p.34). The facilitation project, based on the group identifying non-judgmental approaches to conversations became the basis for developing a positive emotional environment at the SMC. Establishing conditions of non-judgmental acceptance supported opportunities for conversations, reflections, and critical thinking.

Safety, however, had different meanings depending on the women's particular social location. Jasmyn's experiences with other women at the SMC enabled her to trust her feelings. As she describes it, "the philosophy of the Mother Centre, I'm trying to get it personally, being allowed to have emotions, to feel emotions it's like you [are] allowed to be vulnerable, like you're not going to be told you're being too sensitive, like you're being dramatic." Through her interactions with the mothers at the SMC, Jasmyn felt affirmed and in turn invigorated: "You like [being] with other mothers and then in turn once you leave, you're in a better mood, so then you can go on with your day."

For Jasmyn, the SMC provided her a space where she was allowed to be "vulnerable" about the stresses she was experiencing, without being labeled as "dramatic" or "immature" for being emotional. Furthermore, she was able to make a direct connection between the positive feelings that she derived from the interactions where she can be herself with other mothers and her personal

self-care: "[When you] feel more accepted you're going to take better care of yourself and in turn you're probably going to need less you know." As a mother who dealt with postnatal depression after her first birth, she found that emotional safety was paramount and the interactions with other women helped to dissipate the stress of negative emotions.

Finding a safe space is particularly difficult for Indigenous women as they face ongoing, systemic racism. For Sarah, a First Nations woman, the SMC provided a culturally safe space:

> I had struggled to find any sort of place that felt cozy and safe, all the different things I have been involved with I end up feeling like a token Indian; and being involved Mother's Centre that's never happened because there's so many Indigenous people involved in the programming. So, it's that's what draws me in is the fact that there's so much cultural differences and safety and that it's just place that really has captured what I captured in [my] body but I imagine for women like me.

Because many First Nations and Métis, women were at the SMC, there was both "safety in numbers" and a place for women who share a similar identity to Sarah. In contrast, being the "token Indian" was culturally and politically lonely, an experience that Sarah had when she was asked to join the Royal University Hospital Parent Advisory group (field notes). In this situation, Sarah was asked as a "brown body" to represent all Indigenous women because the hospital strived to be more diverse and inclusive. "Token" Indians, however, cannot possibly fulfill this task, and a single Indigenous woman often feels burdened by the weight of this responsibility.

Psychological safety for Sarah meant more than coping with the racialized trauma that she experiences on a regular basis. Rather, she sought positive forms of safety based on affiliating with other Indigenous women as she navigated the terrain of new motherhood. At the SMC, Sarah could see that she could become an effective advocate for Indigenous women:

> I like the politics of it the Mother Centre gives me a bit of a platform too. I take the political route I like a challenge in a bit of a fight and the Mothers' Centre is something to represent so instead of just being the difference of I come in just as one Indigenous voice and now I can come in with knowing that I'm representing an organization that represents all kinds of mothers.

In particular, Sarah was concerned about the connections among food security, breastfeeding, and her identity as a First Nations woman.

> … for babies is so important and access to formula and baby food can be really challenging and expensive and being able to support moms to be able to provide for the child without having to use an outside food sources… not only really important for physical health but really meaningful in the fact that it's something that women have been doing forever and I think it connects us to our natural selves and our ancestors and I just find breastfeeding to be a really important part in that, building that connection.

In her observation on food security, Sarah speaks to her desire to be able to provide for the baby without having to rely on outside sources. This self-sufficiency is a meaningful connection between her desires to be independent and to be reconnected to her "natural" self and her First Nations roots. Sarah's promotion of breastfeeding, particularly among First Nations and Métis women, was in part based on her difficulty in establishing and sustaining breastfeeding as a first-time mother, all the while attempting to complete her grade 12. As a teen mother, experiencing the effects of medical misinformation about breastfeeding and pressure to bottle-feeding opened her up to the oppression that First Nations and Métis women face when they breastfeed. Having become a successful breastfeeding mother with her other children, she recognized the importance of food security that comes with breastfeeding. She also recognized that this knowledge is part of her first Nations culture and connects her to an intergenerational knowledge of self-sufficiency that has been passed down through women. She recognizes the value of breastfeeding as an embodied way to value her body's contribution to the food security and health of her child. This knowledge fuels her advocacy work and agency.

Immigrant women, as we have seen, also have to negotiate the cultural values of their country of origin and those of their new home. For Rahilah, the SMC was that safe space which affirmed her desire to breastfeed her child beyond the so-called normal period of breastfeeding:

> So, when I move to Canada when my daughter was born and I breastfed Iesha to 3½ years, the people was talking to me, 'oh you're not, shame on you, you are

> breastfeeding'. So, I was I was confused and cry too much but since I joined Mother Center and I let her [Iesha the daughter] know I'm a good mother I'm not a bad mother so this is [involvement in the SMC] it's changing my world, totally change my world. My world was I was in dark world all the time thinking oh my gosh what I did but now I'm living in light and I'm so happy because of that.

For Rahilah, going to the SMC was like moving from darkness to light, from disapproval, shame and confusion to knowledge, affirmation, joy, and pride in her abilities as a mother.

The change in biosocial status from non-mother to mother, however, can often lead to changes in social relationships, sometimes resulting in detaching from old relationships as women seek out the support and understanding of women who are also breastfeeding mothers. Kyla, for instance, was a self-styled "party girl," but when she became a breastfeeding mother, she could no longer connect in the same way with her previous social groups: "...when you're a mother, especially when you're a new mother, you don't really have a social circle anymore, you don't really like you're not able to relate as much either to a lot of other people in the community because you're so in enraptured in your motherhood journey." Because Kyla was captivated by motherhood, she had much less in common with her peers who were not mothers. Instead, she felt a need to interact with other mothers: "I think that that is really important for, especially breastfeeding mothers to have access to community, and being able to be around other mothers that are breastfeeding going through the same thing as you is super important." Kyla's connections to the SMC provided her with a community, where she could share her story with other breastfeeding women: "When we get women coming together and interacting with each other on and we are sharing it like personal stories where we're creating a community of people." Storytelling not only enables the storyteller to narrate her life, but also be validated by others.

Becoming and being part of a community is a mutually interactive and beneficial process. Through the SMC, Kyla was able to develop her ability to think independently and critically:

> [W]hen I engaged in community events, I like to have [ ] my two cents put in and [ ]… my ideas and my opinions can help other people and inspire them. And can reinforce positive individualism. So that's how that's how I feel about being a part of the Mother Centre in like being here and wanting to be part of it and what it's meant to me.

Having the space to voice her opinions, her "two cents," enabled Kyla to believe that her views mattered, and as she developed her confidence this newfound sureness would encourage the other women to express their views and "reinforce positive individualism." Her self-assurance helped her to affiliate with the other women: "in like socializing myself, I suppose, getting to know people and support others." Kyla's self-respect and the respect that she received from the other women at the SMC then allowed her to develop her leadership abilities: "I gained a lot of confidence from being able to be a positive encouraging and more like of an inclusive leader in the group and they really helped me personally to see the value in myself."

The SMC not only offered emotional support and various forms of safety, but it was also a place for learning and gaining insights about parenting through conversations with other women and in talking circles. For Ferdousi, the SMC was a space where she could learn more about breastfeeding as a way to process her experiences: "I learned about breastfeeding especially but when I started then I didn't know lots. I now have a lot of experience like I know a lot about breastfeeding, it's really good place… I really appreciate that." Feeling safe and connecting with other women were important ways for her to express her experiences without judgement: "… lots of people over there working is really friendly and you can share anything about anything." For Jasmyn, the SMC was a place that challenged the patriarchal views of motherhood while encouraging her to experiment with different ways of parenting:

> The patriarchal is the world view on mothers and where [ ] there's right and there's wrong. You know 'I'm the mother of you are the child would I say [ ] don't argue with me,' and like by breaking down that system it allows you [ ] to try other ways of parenting without judgment where in other places you might not feel so, so safe to do thing to want to try those things.

Jasmyn's critique focused on the "institution of motherhood" (Rich, 2002), the system that divides mothers into "good" and "bad." She is aware that women have used these norms to compare themselves to other mothers. As a result, many women were unable to integrate mothering into their lives in their own way for fear of being judged (Smyth, 2018). This division between "good" and "bad" mothers is the yardstick often used by health care professionals in

determining whether First Nations and Métis mothers are fulling their responsibilities as primary caregivers. Interactions with the health care system were always potential sites of discrimination and the fear of child apprehensions (field notes). Through the facilitation project, the SMC was able to generate a maternal standpoint of non-judgmental support that provides a new space for interactions and collective agency.

At the SMC, the women learned to trust themselves and others to create an emotionally and culturally safe space. Together, their sense of collective agency promoted an active approach to problem-solving, and an increase in the ability to control the environment at the SMC. Within the organization of mothering talking circles, they were able to discuss and question the restrictions they faced under the patriarchal defined institution of motherhood. Their newly-formed collective agency helped them think together critically and act to "break down the system" so as to integrate non-medical views of mothering and breastfeeding into their own lives. Thus, they were able to create a matricentric pedagogy of care (O'Reilly, 2013), which validated their mothering and sustained breastfeeding practices. The SMC also provided a platform for the women–interacting with health care staff through parent advisory meetings and maternity care talking circles—to bring their narratives to their attention and affect policy changes for the new Children's Hospital being built in Saskatoon.

The narratives of the six participants demonstrated their ability to engage in an active process of finding a foothold and developing their very own capabilities and expertise. The women demonstrated that individually they were able to resist their internalized patriarchal definitions and standards of motherhood to establish their own way to mother through agency, authenticity, and maternal authority. By trusting their bodies as a breastfeeding territory, the women successfully incorporated breastfeeding into their everyday lives. Opportunities for dialogue at the SMC provided participants with a space to exchange experiences of inequities in maternity care as aspects of structural racism rather than personal deficits.

Chapter 5
Conclusion

5.1. Introduction

This study examined the birthing and breastfeeding experiences of six women living in Saskatoon's lowest-income neighborhood, and their capacities to support themselves and one another in a group setting. The research was conducted at the Saskatoon Mothers' Centre (SMC) at Station 20 West. SMC is a nonprofit, charitable organization that was established as an outcome of the collective actions of Saskatoon Breastfeeding Matters, a local community group in partnership with the Health Promotion Department of the Saskatoon Health Region. Through a community driven engagement process, SMC was primarily organized to be a culturally-safe space for First Nations and Métis women and their children, but was welcoming of all women. The Health Promotion Department provided financial resources and staff to support the Centre, the volunteer board, and the hosts in taking on leadership roles at the Centre. The Saskatoon Community Foundation provided funding for the development of a breastfeeding peer support program. Through this program, neighborhood women who worked as hosts at the SMC were provided with breastfeeding peer training and team building opportunities to direct this maternity care support program. After being engaged in providing peer support, some of the women requested additional facilitation skill training to lead weekly maternity care talking circles with an Elder. This interest and request lent itself to a board-approved research project using participatory research methods. The results of this study will be disseminated as a report to the SMC board and membership, Health Promotion Department, Saskatchewan Health Authority, Saskatoon Community Foundation, Saskatoon Breastfeeding Matters, Baby Friendly Initiative Coalition, and Breastfeeding Committee for Saskatchewan. (See Appendix A for a protocol on compassionate care, and Appendix B for the policy implications of this study.)

This research project examined the insights of the six women who took the facilitation training. Five of the six women were identifiable as visible minorities; three of them were First Nations women and the other two were immigrants from non-white, non-English-speaking countries (Afghanistan and Bangladesh). The women shared their stories about their experiences of family and cultural disruptions, overt and covert racism, physical and sexual abuse, and food insecurity and economic hardship. These sharing circles created mutual understandings of the

impacts of structural violence and colonization, personal hardship and trauma, and strength and resiliency.

The basis of their facilitation knowledge came from sharing their own stories of their maternity journey with each other, and their understanding of their own needs for support in the context of the breastfeeding training they had received. Through this process of shared reflections in a group setting, they uncovered what they valued as important in their conversations with one another and in their affiliation with the SMC. This process seemed to deepen their understanding of the needs of other women and to support them. Through facilitation training sessions, they were able to name and practice the conversation elements they wanted to extend to others to ensure safety, confidentiality, and a positive interaction with participants. These elements were aspects of creating safe spaces through generative, non-judgmental conversation and empathic listening skills.

All of the participants negotiated the joys and anxieties of each status change from pregnancy to sustained breastfeeding while developing their capability for self-direction and autonomy. At times, the women demonstrated high levels of determination and resilience to breastfeeding challenges despite messages from medical personnel that they could not or should not breastfeed. At other times, they found themselves unable to resist medical imperatives when maternity-care birthing practices interfered with their capacity to fully establish breastfeeding. These women were engaged in an iterative process of developing forms of self-reliance by reaching out to family, community, and trusted health care providers. Through conversations at the SMC, they became more aware that their ability to adapt to these changes were shaped by their access to social support and material resources. The collective facilitation knowledge the women gained from exchanging stories was used as a guide to provide support for other women coming to the SMC. This process was helpful in providing the women with the confidence to participate in SMC maternity care talking circles and invite hospital maternity care staff, to hear their birth and breastfeeding stories.

5.2. Research Findings

All of the six women stated that they came to realize their intention to breastfeed at some point in their pregnancy. However, they all dealt with challenges in establishing and sustaining breastfeeding. One mother diagnosed with prenatal diabetes, who was subsequently hospitalized for postnatal depression shortly after giving birth, found that she needed to prioritize her own physical care over

breastfeeding her infant. The other five women successfully established and sustained a breastfeeding relationship with their children over time periods ranging from eight months to four years. Four of the five women were able to sustain breastfeeding into the second year and beyond. Meeting the challenges of birthing and breastfeeding for these women were transformative acts of courage, inner strength, and resilience in the face of marginalization and vulnerability.

These five women were able to remain connected to their sensual maternal desires to breastfeed. They were able to integrate their intention to breastfeed, in the midst of their own challenging situations by demonstrated self-efficacy. Defined as "a belief in capability to organize and execute the course of actions required to produce given attainments," self-efficacy is a key (Meedya, 2015, p. 266) to the intrinsic power that builds confidence and success. They demonstrated that they were willing to do what Stearns (2013) calls "dyadic body work" (p. 359) to make breastfeeding work for them and their baby. These five women demonstrated a strong intrinsic belief in their body's capacity to lactate and a trust in their infants' intrinsic cues for frequent feedings without questioning the sufficiency of their milk supply. Maternal practices that support their self-efficacy were in attunement with their infants' feeding and sleeping needs and comfort with bed sharing which has been demonstrated to support successful breastfeeding (Academy of Breastfeeding Medicine, 2020). This attunement, as Baker and McGrath (2011) point out, involves attention to qualities such as acceptance, flexibility, emotional regulation, and timing to provide appropriate responsiveness. Four of the five women were able to experience fully and enjoy their nursing relationships with their child and determine when they would wean.

Given the challenges and trauma that the six women experienced, their transition from pregnancy to birth and breastfeeding was through a series of challenges to their need for safety and autonomy. Birthing and establishing breastfeeding were stressful challenges to their emotional safety in the face of what some of them perceived as depersonalized institutional care. Although these women came from diverse backgrounds, they shared a sense of vulnerability that came from living in poverty, exacerbated by the impact of interlocking systems of race, gender oppression, and violence. Each woman dealt with a unique set of socially-constructed devaluations that contributed to discriminatory encounters when obtaining the care that they needed. Safety, for these women, meant that health care staff would see them as mature women, capable of breastfeeding, and the staff would be respectful of their knowledge and choices.

Psychological safety and autonomy were critical conditions for birthing and learning how to breastfeed. The literature review pointed to the need for the creation of a woman-centered space for each woman to feel emotionally safe and autonomous during the transition from pregnancy to motherhood. All six participants actively worked to create such a space for themselves in their own homes and through relationships of care with care providers they trusted.

From the perspective of capability development, the women who experienced negative assessments of their marginalization from their maternity care providers found that they functioned as additional barriers in establishing their capacity to breastfeed. Although these women understood that their vulnerability increased their risk of being discriminated against, they did not take on the role of victim. Connecting to an intrinsic belief in their capabilities to physically care for their infants by breastfeeding, they were able to develop confidence to do mothering their way; in turn, they were able to articulate their need for psychological safety and actively worked to obtain those conditions. In reaching out to family, health care providers, and the community for care and support, the participants developed new networks of connections that positively changed their sense of themselves and their capabilities.

The experience of breastfeeding was a source of meaning and power for these women. Meeting the challenges of birthing and breastfeeding was a transformative act. The women in this study connected with their internal power through their empowered experiences of breastfeeding their children. They experienced awe in the generosity of the body as a source of self-sufficiency and food security, and in the beauty of the physical act and experienced pleasure in breastfeeding. Dealing directly with their challenges enhanced their self-determination, and in turn their self-determination was supported by their internal capacity for persistence, self-efficacy, resistance, and agency. As a result, these women developed a uniquely maternal standpoint that moved them from "motherhood to mothering" (O'Rielly, 2013, p. 186) through which they acquired autonomy, authority, authenticity and agency based on their experiences of the body-mind-spirit integration.

Establishing breastfeeding was experienced as a maternal practice that was a source of tacit knowledge, maternal identity, and healing. Three of the women dealt with potential debilitating trauma that had the potential to derail their intention to breastfeed. One woman was able to breastfeed through a postpartum depression with the help of her family and a community support group. The other two women had to deal with the effects of childhood sexual abuse and trauma, and reclaiming ownership over their own bodies was the prime goal for both of these young

women. Determined to have the birthing experiences as safe as possible empowered these women to determine who would attend and where they would birth.

Continuing to breastfeed beyond one year has long been seen in Western cultures as "strange" (Giles, 2004, p. 304) and has, historically, been used against Indigenous women to suggest that their parenting style lacked discipline (Nathoo and Ostry, 2009, p. 64). One of the effects of belonging to the SMC peer support group was a sense of the normalcy in continuing to nurse their children through toddlerhood. Five women fully embodied breastfeeding and sustained it past six months[15]. Four of the five women sustained breastfeeding into the second year, and three of them until their child was in their third year. One of the five women found that her baby nursed a lot less after she introduced solid foods which affected her milk supply and was dismayed when the baby subsequently self-weaned at eight months. For the Indigenous women, sustained breastfeeding was a way to reclaim cultural knowledge about breastfeeding. Similarly, the normalcy of sustained breastfeeding was a way for the immigrant women to affirm their traditional knowledge, which had been rejected by their family who perceived that this traditional practice was not acceptable in modern Canadian culture.

Although the women felt vulnerable as they moved from one biosocial status to another, these transitions provided them with opportunities to try new ways of being and new identities. Caring for their infants' needs and dealing with their breastfeeding challenges meant turning inward to develop a new relationship with themselves and necessitated turning outward to connect to others in their families and communities for support. Social networks "provide [the] women with a framework within which to make sense of their experiences and therefore provoke feelings of responsibility that are culturally located" (O'Reilly, 2013, p. 186). Their positive experiences working in breastfeeding peer support program was an opportunity to experience the benefits of being mutually supportive of each other and supportive of those women that came to the Centre. Through this project the participants were able to engage in conversations and reflection on the impacts of the SMC on the development on their well-being and on their mothering capabilities.

Affiliation was a source of integration into a community. SMC provided the space for the opportunity for affiliation to happen. In this space, the women were able to develop a sense of belonging through interactions with each other and team-building activities. These women actively chose to engage in group processes through which they learned self-care and compassionate care

[15] Sustained breastfeeding is defined as continuing to breastfeed fully after complementary foods are introduced at six months.

for each other in the breastfeeding peer support program. Through active engagement in this facilitation training process the participants came realize that breastfeeding practices were embedded in individual circumstances; that non-judgmental communication skills were needed to create emotional safety; and that facilitation skills were required to support maternal confidence in the women that came to the Centre.

Participants were able to provide culturally safe supports to deal with the physical and emotional challenges of breastfeeding. Through sharing stories and reflective conversations about birthing and breastfeeding, the women gained an increased awareness of breastfeeding as an empowered maternal standpoint. They were able to create safe spaces in which they could critically examine their breastfeeding practices, interrogate the biomedical approach, and offer alternative ways and values to their peers. Collectively they were able to participate in maternity care talking circles, share their stories with health care staff and participate in parent advisory committees during the construction of the new Jim Paterson Children's Hospital.

The study demonstrates that the Saskatoon Mothers' Centre as a peer run centre effectively supports the affiliation needs of women who are doing mothering work. Through this facilitation training process, the participants came to realize the bi-weekly breastfeeding support program should be changed to support more women who were not breastfeeding. They made a recommendation to the SMC Board that that a "mothering" talking circle be open to all mothers and grandmothers on Monday afternoons and the Friday evening session be reserved specifically for breastfeeding women. This project thus created weekly "mothering talking circles" to support an open environment where mothering issues could be discussed without fear of being reported to Social Services. This work further supported the development of the SMC as a caring community.

5.3. How Does This Study Contribute to Feminist Knowledge And Research in Lived Experiences?

In her 1990 study of Canadian women, Maclean (1990, p.4) described women's maternity as "an overlooked source of wisdom about the nature of our lives," while Blum (1993) pointed out that maternity experiences can "magnify the cracks and fractures" in our social construction of motherhood (p. 291). In the spirit of these studies, this research utilized a feminist standpoint of lived experience to understand the birthing and breastfeeding experiences of low-income women. This study revealed the tensions and challenges that this group of women faced as they navigated the

health care system. This approach was augmented by the concept of intersectionality, which draws attention to the interlocking systems of race, gender, and class. As a result, this study of these women's maternity experiences identified subjugated knowledge borne out of "frustration, insights and creativity" (Collins, 2002, p. 506). This research moved beyond these concepts by focusing on the development of women's capability as they moved through various biosocial experiences. The development of capability points to the agency and resiliency of the participants, as well as the very real material constraints that can hinder their intention to breastfeed successfully. This study demonstrated that birthing and breastfeeding can be sites for building maternal relationships, developing maternal thinking, and acquiring maternal autonomy and agency that enable women to resist patriarchal/medical mandates of motherhood. In Canadian contexts, breastfeeding has been medicalized and constrained to a health and lifestyle choice. However, many women have overcome the restrictions and uncertainties surrounding sustained breastfeeding and view it as an opportunity to be in community with other breastfeeding women and a source of self-care and healing, growth and development.

For the women in this study who had experienced various types of trauma, breastfeeding was an opportunity for post-traumatic growth that brought wellbeing back into their lives. These women have demonstrated that breastfeeding can be more than a biological process of providing sustenance to their children; it can be an opportunity for building relationships with the child, family, and community. These experiences became sources of meaning and opportunities for care, self-direction, affiliation and collective agency, reinforcing the postmodern feminist understanding of human subjects as interdependent and "beings-in-relation" (Robinson, 2011, p. 10). This view of intersubjectivity suggests that individual maternity rights, for instance the right to birth at home or in hospital, needs to expand to include breastfeeding as a human right and a developmental opportunity through dyadic body work, affiliation and community engagement.

5.4. Future Directions

Food security is key to maternal mental and physical health while maternal physical and mental health are key to healthy child development. When women have sufficient supports to breastfeed, breastfeeding can be both an emotional bond and a material practice that supports attachment, food security, and health for mothers and their children. The role of breastfeeding as a first food and an infant's right to maintaining a feeding relationship that ensures food security requires more study.

For example, milk-sharing as an aspect of food security for an infant whose mother had Crohn's disease, was raised in this study, but it was not a central issue. Nonetheless, the practice of milk-sharing has a history; Indigenous women and wet nurses shared their milk with other infants when their mothers either couldn't or wouldn't breastfeed. Further study of these practices and the meaning attached to milk-sharing under different circumstances requires further study.

The results of this study show, as complexity theory suggests, that small changes can have large effects (Martin et al., 2016). With relatively few resources, the SMC has been able to provide a safe space for women and children and access to community supports making a big difference in women's well-being, and that of their children and the community. In addition to having a positive impact on these individual women's lives, the SMC hosted maternity care talking circles on a quarterly basis for several years. These talking circles lead by an Elder also became opportunities for the women to interact with invited maternity care staff including managers of the maternity ward at the hospital and from the Healthy and Home Program, and the director for maternity care services to share their stories. The purpose was to support the women in having a voice about their maternity care experiences, and to support the women at the SMC who played a role in the parent advisory committees for the new children's hospital. These opportunities for maternity care staff to listen to the community is a potential avenue to affect policy changes. A model of community care such as the SMC's, which supports marginalized women to have voice and agency, can complement the existing medical model of pregnancy, birthing, and breastfeeding. This project demonstrates a synergistic model of community care, which as Katz and Murphy-Shigematsu (2012)) suggest can be a potential resource to empower people in community to become part of a holistic health care system.

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Appendix A

Compassionate Maternity Care

Compassionate care provides safety through respectful collaboration, understanding, trust, and empowerment can be an effective way to provide a trauma informed woman-centered approach to birthing and breastfeeding. Based on Elliot et al.'s principles of trauma-informed care, compassionate maternity care would include:

1) Recognition that childbirth has the potential for trauma or retraumatization to occur.
2) Collaboration with the mother to create a protected woman-centered space that provides her with acceptance, safety, and privacy, along with cultural and language supports that "maximizes" her choices and control over her recovery.
3) Recognition that marginalized women are not just victims, but demonstrate resilience in the face of duress. Using a strength-based approach to help women connect with their capability for self-direction, role integration, affiliation and wellness.
4) Facilitated conversations with women that connect with their feelings and their needs, and help them connect to their inner capacities of intention, agency, and responsibility for themselves and for their child.
5) Recognition that breastfeeding is more than a way to feed a baby. There are spiritual, cultural, social and material meanings attached to breastfeeding that connect women to community knowledge about breastfeeding as an intergenerational relationship bond and an ethic of care. Breastfeeding can be experienced as an empowered esthetic that can bring meaning to women's lives; it can be a source of bonding and attachment, nurturance, a route to healing and well-being, and a source of food sovereignty and security that is connected to community knowledge and support systems.
6) Provision of emotional care for a woman who chooses not to breastfeed as she may be dealing with a difficult choice through the intersectional impacts of structural violence on her resources for self-care and mother care.
7) Engages marginalized women in the evaluation of maternity care services.

Appendix B

Policy Implications

The international gold standard for maternity care practices is the Baby Friendly Initiative (BFI) Ten steps to Successful Breastfeeding. This evidence-based policy is a prescriptive set of maternity staff practices for patient-centered care to assist with the establishment of exclusive breastfeeding. The BFI policy is silent on the emotional safety that is needed to support marginalized women to birth in ways that provide trauma-informed care that is supportive of marginalized women's desire to breastfeed. The findings of this study contribute to the scholarly literature that highlights the importance of creating space for a woman-centered territory that recognizes women's intentions for autonomy and safety through the transition from birthing to breastfeeding.

For mothers in this study, the capacity to breastfeed started in the labour room with the birth practices. These women intuitively understood that a "birthing territory" over which they had control would impact their capacity to initiate breastfeeding and recognize their capability to become breastfeeding mothers. A key component in creating this safe environment was the women's trust in their health care providers. When nurses and midwives took the time to listen and support these women, breastfeeding was a more likely outcome. Elements of the medical system—a lack of attention to the women's emotional safety; adherence to a model of "efficient" care–often imposed by understaffing; the promotion of infant formula–and presumably lack of knowledge about breastfeeding; an unconscious acceptance of institutional motherhood, standards based on white, middle-class values; and paternalistic and/or outright racist attitudes tended to undermine or constrain the development of these trust relationships.

Access to a midwife for a home birth in Saskatoon is problematic especially if you are part of a vulnerable group. With nearly 6,000 women giving birth a year at RUH, there is limited access to the seven midwives presently working in Saskatoon. In this health region, following Manitoba's lead that 40%-50% of "priority populations" should be handled by midwives, midwifery care has been mandated for vulnerable women in this health region. Yet the Saskatoon Health Region (SHR) data for 2011 indicated that of the 268 midwifery clients served over a 12-month period, only 6% were from priority population (Hanson and McRae 10).

For First Nations women in this study, the risk of being judged an unfit mother and the risk of losing the child to the Social Services foster care system was ever present. Women who deal with marginalization and care deficits need to be understood within a larger context of racist

relations, poverty, and stereotypes. Many Indigenous people value breastfeeding as the sacred connection between women and their child, and breastfeeding skills they used were an important aspect of Indigenous midwifery knowledge (Simpson 26-27). Through colonization, breastfeeding was discouraged and devalued as an Indigenous practice (K. Anderson 61-62). In a kokums' meeting held recently in Saskatoon as part of the Saskatchewan Indigenous Birth Network–a new organization established to recover Indigenous birth knowledge–one grandmother recalled how women she knew were discouraged from breastfeeding because "dogs feed their young that way" (field notes).

The women in this study experienced health care workers' perception of their marginalization in contradictory ways. At times marginalization was both a source of additional institutional care, such as preferential access to midwifery care, and at other times as paternalism and racist attitudes that undermined the women's self-confidence. The women perceived these messages as having a negative impact on the capability to birth and breastfeed. Applying the capability perspective to the lives of marginalized women means, however, that health care professionals have to let go of their paternalistic views of this group of women. Despite the challenges of poverty and racism, the participants in this study demonstrated various forms of resiliency, self-care, internal power, and peer support, particularly when given the opportunity to develop these skills. The women's stories emphasized the need for policy changes and professional education to better connect birthing and breastfeeding, and marginalized women's needs for a woman-centered space where they can develop their capability to become a breastfeeding mother.

Appendix C

Ethics Materials

Agreement provided by the Centre for Indigenous Peoples' Nutrition and Environment (CINE)

Project Title: Impacts of Breastfeeding Peer Support Program on Women's Capacity to Support Themselves and Others

Research Agreement (October 27, 2017)

University of Saskatchewan (Johanna Bergerman MA student, supervised by Lesley Biggs Department of History, College of Arts and Science) agree to conduct the named research project with the following understandings:

1. The purpose of this research project, as discussed with and understood in the community of The Saskatoon Mothers' Centre (SMC) is that this research project will support the hosts of the SMC in their capacity building processes to enhance their facilitation skills in their breastfeeding peer support work.

2. The scope of this research project (that is, what issue, events or activities are to be involved, and the degree of participation by community residents), as discussed with and understood in this community, is: that the hosts who self-select to be involved in a facilitation training process will work together to provide training and mentorship for new hosts to the program.

3. The methods to be used, as agreed by the researchers and the community, are: mixed methods, quantitative and qualitative using Participatory Action research and focus groups by way of traditional talking circles.

4. Community training and participation, as agreed, are to include: any and all the hosts that presently work at the SMC are interested to be involved in the facilitation training process as co researchers.

The development of this project is based on sincere communication between peer breast-feeding support hosts and myself. All efforts will be made to incorporate and address local concerns and recommendations at each step of the project.

At the end of the project, the researchers will participate in a talking circle to discuss the results of the analysis with an Elder, Judy Pelly, and with the talking circle facilitator, Dr. Tara Turner.

5. Information collected is to be shared, distributed, and stored in these agreed ways: Data collected will involve a written paragraph on that host understandings of facilitation processes before and after the training. Interviews before the training occurs will be taped. The data collected is confidential with name is attached to a record. Copies will be kept at SMC where the data will be converted to an electronic form. The data will be kept on USB drive in the community, at the SMC. The researcher will be available to answer questions and assist community members should community members decide to use the data for different purposes; a final report will be distributed after approval from the community members.

6. Informed consent of individual participants is to be obtained in these agreed ways:

   An individual consent form will be read by the interviewer to the respondent. A copy of the consent form will be left with the respondent where the address of each researcher can be used at any time, should the respondent wish to contact the researcher(s) for additional information.

7. The names of participants and of the community are to be protected in these agreed ways:

   As mentioned on the consent form, the interviews are confidential. Before distribution of the final report, or any publication or contact with the media, the Breastfeeding peer supporters will be consulted once again as to whether they will agree to share this data in that particular way.

8. Project progress will be communicated to the community in these agreed ways: a regular update will be provided at the monthly SMC board meetings.

9. Communication with the media and other parties (including Saskatoon Community Foundation) outside the named researchers and the SMC will be handled in these agreed ways:

Funding, benefits and commitments

Funding

The main researchers have received funding and other forms of support for this research project from: Saskatoon Community foundation is funding the breastfeeding peer support program as a capacity building program for the SMC.

The funding agency has not imposed any criteria, disclosures, limitations, and reporting responsibilities on the main researchers.

Benefits

The main researchers wish to use this research project for their benefit in the following ways: to coauthor with the participants, a report to the board and a journal article; to support personal decolonization practices; to support developing participatory action research skills with breastfeeding peer support workers; to present this work at breastfeeding and feminist conferences.

The researchers will submit a final report to the Saskatoon Community Foundation in 2018.

The benefits likely to be gained by the community through this research project are:

- Skill building: learning tighter how to enhance their facilitation skills
- Capacity building through reflective practices and talking circles
- Educational: learning their cultural practices associated with breastfeeding support work
- Financial: hosts will be paid their regular honorarium during this leadership training work

Commitments

The community's commitment to the researchers is to:

- Recommend capable and reliable community members to collaborate or to be employed in this project.
- Keep informed about the progress of the project, and help in leading the project toward meaningful results.

The researchers' main commitment to the community is to:

- Support the participants in enhancing their facilitation skills by supporting a strength based education process.
- Inform the SMC about the progress of the project in a clear, specific, and timely manner at each board meeting.
- Act as a resource to the SMC on peer support programing questions.

The researchers agree to interrupt the research project in the following circumstances:

- If SMC board decide to withdraw their participation.
- If the researchers believe that the project will no-longer benefit the community.

Signed by:

Date: November 1/2017

(Signature of Main Researcher)
Name: Johanna Bergerman
Position: MJST MA Student.

Date: November 1, 2017
Community: Saskatoon Mothers' Centre

(Signature of Community Contact Person)
Name: Tara Turner
Position: Associate Professor, FNUniv

Appendix D

Interview Guide for Interview Participation

Interview Guide for interview participation

You are invited to participate in a research study entitled:

Impacts of Breastfeeding Peer Support Programs on women's capacity to support themselves and others

Researcher: Johanna Bergerman MA Student WGST, University of Saskatchewan
Phone: 306 3740 0400; Email: jeb149@mail.usask.ca

Supervisor: Lesley Biggs, Department of History 9 Campus Dr. Department of History University of Saskatchewan S7N 5A5 Phone: 306 966 1645 Email: lesley.biggs@usask.ca

Purpose(s) and Objective(s) of the Research:
This research project will support the hosts of the Saskatoon Mothers'' Centre (SMC) individually and as a group in their capacity building processes. All hosts that have previously been trained as breastfeeding peer support are invited to engage in training and mentoring new hosts. The project builds on the hosts expressed desire to enhance their facilitation skills in their breastfeeding peer support work. Data will be collected before and after the training. I will analyze the data. The hosts will review the analysis and generate their recommendations of their experiences as a report back to the SMC board.

Interview questions:

Questions will fall under Self, Us and Now (Ganz Telling your Public story)

1. Your breastfeeding story:

- Tell me about your experiences as a mother with infant feeding
- What has been a challenge?
- What choices did you make?
- How did the outcomes feel?
- What did you learn that you would like to share with other mothers?

2. How has participating in peer support work at the SMC with other peer supporters affecting your knowledge of breastfeeding?

3. How do you see being involved in facilitation training affecting your knowledge and skills?

Appendix E

SMC Research Project Themes

Discussion of themes arising from the data collected with the participants and shared with them on 18 June 2018

Research Themes: SMC work provides a safe space for the women who provide services in that space. Working at the SMC has an impact on women's personal lives and the lives of each other in the following ways:

- **Food Security**: access issues, formula is expensive, self-reliance, good nutrition, breastfeeding as free, freedom of worry about what to feed the baby.

- **Connections**: To inner resources; "natural "selves and to ancestors, to intuition, to caring
  To community: to other women who are going thorough experiences of becoming mothers
  To different community organizations that come to MC
  To health region support

- **Safety and Respect**: warm welcome, respect for diversity, open to different cultural backgrounds
  Acceptance: Dealing with exhaustion, being allowed to have emotions, feel emotions, feel more accepted linked to taking better care of self
  Self-care: role modeling self-care through SMC programs
  Pressure and resistance: resistance to social and family pressure to wean,

- **Transformational experiences**: support for positive experiences of connections, own journey towards motherhood, to figuring out a career, life changing experiences, reevaluation of own experiences,

- **Rites of passage**: sharing motherhood experiences with other women through storytelling, affirming one another, affirming womanhood
  Using facilitation skills in leading group discussion and in personal life as a positive experience of skill building "Opens me up to different world views' "Let's me try different ways of parenting"

- **Community building**: women coming together interacting, telling personal stories sharing challenges and experiences.

- **Community impacts**: changed attitudes to sustained breastfeeding; long term impacts on health for next generation, filling the gap for families that do not have connections to grandmothers.

- **Voice**: SMC represents a collective thus strengthens voice to address birthing issues at the Royal University Hospital